

# CLIFTON RECREATION DEPARTMENT PROGRAM REGISTRATION

PARTICIPANT'S NAME: \_\_\_\_\_ REGISTRATION #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME #: \_\_\_\_\_ CELL #: \_\_\_\_\_ EMAIL: \_\_\_\_\_

GENDER: M / F AGE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_

SPECIFIC INFORMATION / EXPERIENCE / SPECIAL CONCERNS: \_\_\_\_\_  
\_\_\_\_\_

PROGRAM / ACTIVITY: \_\_\_\_\_ LEVEL / DIVISION: \_\_\_\_\_

DAY(S): \_\_\_\_\_ TIME: \_\_\_\_\_ FEE: \_\_\_\_\_

PARTICIPANT / PARENT / GUARDIAN AGREES THAT HE / SHE IS IN GOOD HEALTH AND PHYSICALLY ABLE TO PARTICIPATE IN THE SPORT / ACTIVITY AND FURTHER AGREES THAT THE CITY OF CLIFTON AND / OR ITS AGENTS / MEMBERS OR EMPLOYEES SHALL NOT BE LIABLE IN THE EVENT OF AN ACCIDENT, INJURY OR ANY DAMAGE WHATSOEVER, ARISING FROM PARTICIPATION OR PRESENCE IN OR AT SAID ACTIVITY. I GRANT THE CITY OF CLIFTON MY PERMISSION TO USE PHOTOGRPHS, SLIDES OR VIDEOTAPES TAKEN DURING PARTICIPATION IN THE ABOVE SPORT / ACTIVITY TO BE USED IN LEGITIMATE CITY PROMOTIONS. I FUTHER GRANT PERMISSION TO THE CITY OF CLIFTON TO AUTHORIZE MEDICAL CARE FOR ME OR MY CHILD IN AN EXTREME EMERGENCY.

\_\_\_\_\_  
SIGNATURE (PARENT IF MINOR)

\_\_\_\_\_  
DATE

----- OFFICE USE -----

RANK: \_\_\_\_\_ TEAM: \_\_\_\_\_ BIRTH CERT. \_\_\_\_\_ RESIDENCY: \_\_\_\_\_ RECEIPT #: \_\_\_\_\_  
  
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