

BOW PARKS & RECREATION FAMILY REGISTRATION FORM

RETURN WITH PAYMENT TO:

- Stop in at the Recreation Office located at the Bow Community Center, 3 Bow Center Rd.
- Drop in our secured Drop Box located at the Bow Community Center
- Mail to 10 Grandview Road, Bow NH 03304.

CONTACT US AT:

Office Phone: 603-223-3920
 Fax: 603-228-2230
 Website: www.bownh.gov

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|--|---------------------------------|-------------------|--|------------------|----------------------|
| PARTICIPANT INFO | 1. Parent First & Last Name | Age | Sex | Date Of Birth | |
| | 2. Parent First & Last Name | Age | Sex | Date Of Birth | |
| | 3. Child First & Last Name | Age/Grade | Sex | Date Of Birth | Parent/Guardian Name |
| | 4. Child First & Last Name | Age/Grade | Sex | Date Of Birth | Parent/Guardian Name |
| | 5. Child First & Last Name | Age/Grade | Sex | Date Of Birth | Parent/Guardian Name |
| | 6. Child First & Last Name | Age/Grade | Sex | Date Of Birth | Parent/Guardian Name |
| | | Address | City | State | Zip |
| REMINDER: Please notify office staff of ANY changes with contact info or medical updates. Thank-you! | Phone #'s | (Home) | (Work) | (Cell) | |
| | E-Mail | | | | |
| | In an emergency, please contact | | Relationship | Phone #'s | |
| PHYSICIAN INFO Please list any Medical Conditions or Medications on the back of this page for each participant. | 1. Physician's Name | Physician's Phone | Does participant carry an inhaler? YES: <input type="checkbox"/> NO: <input type="checkbox"/> Does participant carry an EpiPen®? YES: <input type="checkbox"/> NO: <input type="checkbox"/> | | |
| | 2. Physician's Name | Physician's Phone | Does participant carry an inhaler? YES: <input type="checkbox"/> NO: <input type="checkbox"/> Does participant carry an EpiPen®? YES: <input type="checkbox"/> NO: <input type="checkbox"/> | | |
| | 3. Physician's Name | Physician's Phone | Does participant carry an inhaler? YES: <input type="checkbox"/> NO: <input type="checkbox"/> Does participant carry an EpiPen®? YES: <input type="checkbox"/> NO: <input type="checkbox"/> | | |
| | 4. Physician's Name | Physician's Phone | Does participant carry an inhaler? YES: <input type="checkbox"/> NO: <input type="checkbox"/> Does participant carry an EpiPen®? YES: <input type="checkbox"/> NO: <input type="checkbox"/> | | |
| | 5. Physician's Name | Physician's Phone | Does participant carry an inhaler? YES: <input type="checkbox"/> NO: <input type="checkbox"/> Does participant carry an EpiPen®? YES: <input type="checkbox"/> NO: <input type="checkbox"/> | | |
| | 6. Physician's Name | Physician's Phone | Does participant carry an inhaler? YES: <input type="checkbox"/> NO: <input type="checkbox"/> Does participant carry an EpiPen®? YES: <input type="checkbox"/> NO: <input type="checkbox"/> | | |
| | | | | | |
| Program | Session/Date/Time | Fee Paid | Check #/Cash | Date Paid | |
| | | | | | |

****PLEASE READ AND SIGN THE WAIVER BELOW****

Participation in this sport/activity may involve risk of injury. As a participant or parent, I am aware of these hazards and my ability to participate. In consideration for participation in the program(s) listed above, I hereby for myself, my heirs, executors and administrators waive and release all rights and claims against the Town of Bow, its officers, employees, agents, volunteers and supervisors, except in the case of their sole negligence, from all losses, injury, damages, fees and other expenses, arising out of or in connection with participation in the activity. In addition, I give my permission for the above participant to be treated by qualified medical personnel in the event that the parent/guardian/emergency contact named above can not be reached at the phone numbers provided.

I give permission to Parks & Recreation to use participants' photo for display or advertisement by the Town of Bow, Parks & Recreation Department.

REFUND PROCEDURE - Refunds are issued only when a class is cancelled by the Recreation Department or the participant enrolled in the program has a note from a physician's office stating they are not able to participate in the program because of a medical condition.

SIGNATURE (parent/guardian if participant is under 18 years of age)

DATE