

Registration Form (Please Print)

City of Menlo Park
 Community Services Department
 (650) 330-2200
 Fax (650) 324-1721 or (650) 327-7046



Participant(s): _____ Parent/Guardian Name: _____
 Last Name: _____ Name: _____
 New Address Home Phone: () _____
 Address: _____ Work Phone: () _____
 City/Zip: _____ Would you like to receive Community Services Yes ()
 Department information via email? No ()
 Email: _____
 Emergency Relationship: _____
 Contact Name: _____ Phone: () _____

Registration #	First Name	Birth Date	Class Name, Date, Time	Class Fee	Alternative Reg #

RESIDENT FEES: To qualify, you must submit a copy of your utility bill or Driver's license showing your current address within incorporated Menlo Park (P.O. Box is not acceptable).

Total _____

PAYMENT METHOD: Check one

<input type="checkbox"/> Check MAIL-IN Community Services Department 701 Laurel Street, Menlo Park, CA 94025 Make check Payable to: City Of Menlo Park \$30 charge for returned checks WALK-IN Rec. Center, 700 Alma St.	<input type="checkbox"/> Visa card <input type="checkbox"/> MasterCard Expiration Date: _____ Account #: _____ Account Holder Name: _____ I agree to pay the above charges. I authorize the City of Menlo Park to charge these costs to my credit card. Authorized Signature: _____	FAX (650) 324-1721 or (650) 327-7046 MAIL-IN/WALK-IN: "see address"
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Refund and Transfer Policies:

If you cannot attend an activity or find the class not meeting your expectations, it is possible to request either a transfer or a refund. Your request will be prorated and assessed as follows: If you choose to transfer, we will apply the prorated amount of your enrollment fee to any other course within that session. If you prefer to receive a refund, a \$15 processing fee will be deducted from the prorated fee based on the date of the request, unless otherwise noted in our publication. All refund or transfer requests for classes with material fees or with two or fewer class meetings must be received one week prior to the class starting date. If the course is cancelled you will receive a full refund or you can request to transfer to another class.

I, the undersigned parent, guardian, or participant do hereby agree to allow the individual(s) named herein to participate in the aforementioned activity (ties) and I further agree to indemnify the Community Services Department, the City, its employees and officers harmless from and against any and all liability for any injury which may be suffered by the aforementioned individual(s) arising out of or in any way connected with the participation in this activity. I further agree to permit the use of event/activity photography and/or video media production, which may include images of myself or individuals above.

Signature: _____ Date: _____ Circle one: Parent Guardian Participant

Do you have any special needs that require specific accommodations so you can fully enjoy one of our classes or facilities?

Official Use Only

Receipt #	Date	Residency Verified	Processed By
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MEDICAL HISTORY SURVEY
FOR GYMNASTICS CLASSES ONLY

Participant's Name _____

- | | | |
|---|-----------|------------|
| 1. Does participant have any condition that would preclude or limit participation in our programs? If yes, please explain: _____ | NO | YES |
| 2. Has participant ever been informed that they have Asthma?
If so, is it controlled by medication YES NO | NO | YES |
| 3. Has participant ever been informed that they might have epilepsy, or ever experienced a seizure? | NO | YES |
| 4. Has participant been treated for infectious mononucleosis, viral pneumonia, or another infectious disease during the past twelve months? | NO | YES |
| 5. Has participant ever been treated for or informed by a medical doctor that they have a heart problem, a heart murmur, or high blood pressure? | NO | YES |
| 6. Has participant ever been told they had hemophilia or other bleeding disorders or currently have easy bleeding or bruising? | NO | YES |
| 7. Has participant ever been told that they have a hernia? If so, it is repaired? | NO | YES |
| 8. Has participant had any operations in the past two years? If yes, indicate the anatomical site and date: _____ | NO | YES |
| 9. Is participant currently taking prescribed medications? If so, indicate name of drug and indicate why it is prescribed: _____
_____ | NO | YES |
| 10. Has participant ever been treated for Osgood-Schlatter (knee) Disease? | NO | YES |
| 11. Has participant had a fracture during the past two years? If yes, indicate the site of the fracture and the date: _____ | NO | YES |
| 12. Has participant had any joint dislocation during the past two years? If so, please indicate which joint: _____ | NO | YES |
| 13. Does participant ever experience pain in the back?
If yes, indicate frequency by circling the answer:
SELDOM / OCCASIONALLY / FREQUENTLY / ONLY ON VIGOROUS EXERCISE or HEAVY LIFTING. | NO | YES |
| 14. Is participant allergic to penicillin or any other medications?
If so, please list: _____ | NO | YES |
| 15. Have there been any disciplinary, emotional, learning disabilities or other concerns, which we should be aware of? If so, please explain:

_____ | | |

COMMENTS:

PARENT/GUARDIAN/STUDENT: All of the above questions have been answered completely and truthfully to the best of our knowledge.

Date

Parent Signature

Date

Student (over 18) Signature