

# ENROLLMENT FORM

Use this form to sign-up for classes, programs, leagues and teams.



## PRIMARY ADULT AND HOUSEHOLD INFORMATION

LAST NAME, FIRST NAME \_\_\_\_\_ DATE \_\_\_\_\_

PHONE \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

THIS PERSON IS:  A PARENT/GUARDIAN       AN EMERGENCY CONTACT       AUTHORIZED TO PICK UP MY CHILD

## ADDITIONAL CONTACTS

THIS PERSON IS:  A PARENT/GUARDIAN       AN EMERGENCY CONTACT       AUTHORIZED TO PICK UP MY CHILD

NAME \_\_\_\_\_  MALE  FEMALE

EMAIL \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_

PHONE: HOME \_\_\_\_\_ MOBILE \_\_\_\_\_ WORK \_\_\_\_\_

THIS PERSON IS:  A PARENT/GUARDIAN       AN EMERGENCY CONTACT       AUTHORIZED TO PICK UP MY CHILD

NAME \_\_\_\_\_  MALE  FEMALE

EMAIL \_\_\_\_\_ RELATIONSHIP TO CHILD \_\_\_\_\_

PHONE: HOME \_\_\_\_\_ MOBILE \_\_\_\_\_ WORK \_\_\_\_\_

## CLASS INFORMATION

CLASS/PROGRAM NAME	DATES	DAYS	TIME	PARTICIPANTS NAME	SHIRT SIZE	DATE OF BIRTH	GRADE	FEE \$

SUBTOTAL	\$
LESS GOLD MEMBER 10% DISCOUNT	-
GRAND TOTAL	\$

## SPECIAL REQUESTS

Please list any special needs, allergies, medication, learning disabilities or any other information we may need to make your experience a positive one.

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## PAYMENT INFORMATION

I AM PAYING WITH CASH/CHECK      CHECK # \_\_\_\_\_       CHARGE MY CREDIT CARD       VISA       MASTERCARD

I authorize The Salvation Army Kroc Center to charge my credit card indicated below.

NAME (AS IT APPEARS ON CARD) \_\_\_\_\_

CARD NUMBER \_\_\_\_\_

SIGNATURE \_\_\_\_\_

EXPIRATION DATE (MM/YY) \_\_\_\_\_

TODAY'S DATE \_\_\_\_\_

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## LIABILITY WAIVER

My child has permission to self sign out at the conclusion of this program each day. MEMBER INITIALS: \_\_\_\_\_

By signing this document I (we) agree to the following terms: In case of illness or accident The Salvation Army Kroc Center is authorized to secure emergency medical treatment at my expense. The Salvation Army Kroc Center reserves the right to dismiss any participant who does not show respect for the facility, including but not limited to: property, equipment, policies, other members and staff. Members who are dismissed will not be given a refund of fees paid. The Salvation Army Kroc Center assumes no responsibility for personal property that is either in or out of lockers. By signing this Class/Program Enrollment Form, I (we) hereby waive any and all claims against The Salvation Army Kroc Center. I understand that use of the facilities and equipment at The Salvation Army Kroc Center may involve risk of bodily injury or property damage and I agree to assume any such risks. I understand that it is up to me to consult physicians and other professionals to make sure that I can safely participate in activities and events at The Salvation Army Kroc Center. I also understand and agree that by signing this Agreement, I am giving up my (or the minor for whom I sign) right to make any claim against The Salvation Army, its agents, employees and volunteers, including the right to sue them, for bodily injury or property damage or any other loss that I might suffer while using The Salvation Army Kroc Center facilities and services, except as limited by law.

NOTICE - In order to promote a safe and secure environment, The Salvation Army Kroc Center has placed video cameras in various locations. As part of our commitment to the safety of children and vulnerable persons, The Salvation Army Kroc Center reserves the right to consult public sources to determine whether any member or guest of any member poses an unreasonable risk of harm to its patrons, staff, or visitors. The Salvation Army Ray and Joan Kroc Corps Community Center may use the above listed participants photo for promotional purposes. For information regarding The Kroc Center's cancellation policy, please see the program guide.

NAME, PLEASE PRINT \_\_\_\_\_

DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

YOUTH PARTICIPANT (PARENT/GUARDIAN SIGNATURE) \_\_\_\_\_

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## CHILD MEDICAL FORM

This form will be on hand at all activities. It must be presented upon admission for treatment.

STUDENT'S FULL NAME \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

AGE \_\_\_\_\_

### Participant Medical Information

HEALTH INSURANCE PROVIDER POLICY NUMBER: \_\_\_\_\_

CITY AND STATE: \_\_\_\_\_

PHONE: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_

DENTIST/ORTHODONTIST NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_

#### Does camper have any of the following conditions?

- |  |  |
|--|--|
| <input type="radio"/> Asthma                 | <input type="radio"/> Sinus Trouble            |
| <input type="radio"/> Allergies (general)    | <input type="radio"/> Sleep Walking            |
| <input type="radio"/> Bee sting allergy      | <input type="radio"/> Bed Wetting              |
| <input type="radio"/> Poison oak allergy     | <input type="radio"/> Frequent ear infections  |
| <input type="radio"/> Car/motion sickness    | <input type="radio"/> Diabetes                 |
| <input type="radio"/> Bowel/bladder problems | <input type="radio"/> Blood/clotting disorders |
| <input type="radio"/> Epilepsy/convulsions   | <input type="radio"/> Fainting/dizzy spells    |
| <input type="radio"/> Hay fever              | <input type="radio"/> Nosebleeds               |
| <input type="radio"/> Heart trouble/murmur   | <input type="radio"/> Hypertension             |
| <input type="radio"/> Headaches              | <input type="radio"/> Other (Please explain)   |
| <input type="radio"/> Backaches/weak back    |  |
| <input type="radio"/> Respiratory problems   |  |

#### Does participant have any food or drug allergies or special dietary requirements?    Yes    No    If Yes, Please Explain:

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#### Has participant ever had any serious injuries or operations?

Yes     No    If Yes, Please Explain: \_\_\_\_\_

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#### Has participant Ever Required Psychiatric Counseling Or Hospitalization?

Yes     No    If Yes, Please Explain: \_\_\_\_\_

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#### Is participant Required To Take Any Medications?    Yes    No

If Yes, Please Explain: (Medication, Name, Reason, Dosage, Taken, When, Etc): \_\_\_\_\_

Mark the month and year the camper had the following immunizations:

Tetanus \_\_\_\_\_

Measles \_\_\_\_\_

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#### Is participant Capable Of Participating In Strenuous Activities?

Yes     No    If No, Please Explain: \_\_\_\_\_

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