

Youth Registration

Mail to: Ridgefield Community Ed, 510 Pioneer Street, Ridgefield WA 98642

Name (Last) _____ (First) _____

Age _____ Grade _____ School _____ Shirt Size YM YL AS AM AL

Address _____ City _____ Zip _____

Home # _____ Work # _____ Cell # _____

Parent/guardian names _____

Emergency contact _____ Phone _____

Parent permission:

_____ has my permission to participate in the Community Education Program. In an emergency I grant permission for emergency medical treatment to be administered to my child. I agree to pay all medical bills not covered by my insurance company listed below. I release Ridgefield School District from responsibility for any bills resulting from injuries incurred in this program. While no sports physical is required to participate, I understand that my child should be in good physical condition and that a current medical exam is strongly recommended. I understand the risks of participating in this sports activity. I have listed information regarding allergies and/or medical conditions about my child of which staff should be aware.

Does your child have any allergies of medical conditions that staff should be aware of? _____

If yes, please explain _____

Parent/guardian signature _____ Date _____

Insurance co. _____ Policy # _____

Physician's name _____ Phone# _____

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