

# Willington Youth, Family & Social Services

"Where Community Grows"



40 Old Farms Rd  
Willington, CT 06279  
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Fax: 860-487-3125  
[wyfss@willingtonct.org](mailto:wfyss@willingtonct.org)

TWON OF WILLINGTON  
YOUTH PROGRAMMING

**FIRST FRIDAY HANG OUT**

## REGISTRATION 2009

Student's

Name \_\_\_\_\_ Grade \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Alt. Phone (\_\_\_\_\_) \_\_\_\_\_

Is it OK to leave messages on these numbers? \_\_\_\_\_ Yes \_\_\_\_\_ No

Street

Address \_\_\_\_\_ Willington, CT 06279

Do you receive your mail at this address? \_\_\_\_\_ Yes \_\_\_\_\_ No

Parent/Guardian

Name(s): \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

## Emergency/Medical Information

Contact in case of an emergency (other than parent)

Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Relationship \_\_\_\_\_ Alt. Phone (\_\_\_\_\_) \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Does your child have any of the following?

Food Allergies? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, explain \_\_\_\_\_

Emergency medications? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, explain \_\_\_\_\_

Physical or emotional conditions that we should be aware of?

\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, explain \_\_\_\_\_

OVER ►►►

## **Release, Waiver and Assumption of Liability**

I, the undersigned, by registering my child to participate in The Willington New Horizon Girl's Club understand the nature and risks associated with participation in this activity. I hereby grant my child permission to participate. I am aware that participation is at one's own risk. I acknowledge that the activity, equipment and facilities may pose a risk of personal injury. I am also aware that each participant is responsible for her own safety. I hereby waive and release myself, my heirs, executors or administrators of any and all claims and damage we ever had or now have, against the Town of Willington, its successors and assigns, employees, agents and representatives of any and all kinds of injury, including but not limited to personal injury and/or property damage suffered by my child, myself, family members or friends while participating in this program.

## **Consent for Medical Treatment**

Consent for Medical Treatment of Minors, as the parent or legal guardian of the above named participant, I hereby give consent for emergency medical care prescribed by a fully licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my dependant. I certify that the information contained on this form is accurate and complete.

## **Consent for use of Image**

\_\_\_\_ I grant WYFSS the permission to use my child's image on its homepage, fliers, or newspaper articles for the sole purposes of program promotion/publicity.

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Parent/Guardian Signature

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Date