St.Clairsville Rec Center

Indoor Soccer

Online & Paper Registration open until : Jan. 12, 2018

Location: ST.C Recreation Center Gymnasium

Game Days: Thursday, Friday & Saturday

February 1—March 24

Fee: $50 Residents/ $60 Non Residents

Family Fee: $85 Residents/ $95 Non Residents

Participant Name: _____ Gender: Boy Girl

Age:_____ DOB: _____ T-Shirt Size : Youth S M L

Adult S M L XL

Mailing Address for child:

_____

_____

Parent/Guardian Name: _____

Home Phone: _____ Payment Method: Cash Check Online

Cell Phone: _____ Amt Paid:_____ Date Paid: _____

Work Phone (Optional): _____ Payment Accepted By: _____

Email: _____

Allergies/Medical Conditions:

_____

_____

Please ensure you sign the medical waiver on the back side of the page!

Parent Signature: _____ Date: _____

Online Registration, Schedules, Changes, Updates and all other information can be found by going to https://stcrecdept.recdesk.com !

St·Clairsville Department of Parks & Recreation

Emergency Medical Authorization

Purpose: To enable parents and guardians of participants to authorize the provision of emergency treatment for the children or participants who become ill or injured while under Dept. of Parks & Recreation activities when the parent or guardian cannot be reached.

Participants Name: _____Program Participating In: _____

Part I (To Grant Consent):

In the event reasonable attempts to contact me , _____at _____*(phone number)* or _____*(cell phone)* have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the following doctors:

Preferred Physician Name & Phone: _____

Preferred Dentist Name & Phone: _____

In the event the designated practitioner is not available, I consent to care by another licensed physician or dentist. If the transfer of _____*(participant's name)* is necessary I grant consent of the transfer to _____*(preferred hospital)* for any reasonable and necessary care. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the participant's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted in the space provided below:

_____

_____

Signature: _____ Date: _____

HIPPA Consent:

The St.Clairsville Department of Parks & Recreation acknowledge and abides by all rules of the HIPPA Act.

Yes, I do consent to release emergency medical information on this form to the Recreation Department office staff, emergency personnel and coaches.

No, I do consent to release any or all information pertaining to my child.

Parent Signature: _____ Date: _____

Participant Signature: _____ Date: _____

(If participant is over 18) Revised on 8.25.14

Do NOT complete Part II if you completed Part I

Part II (Refusal to Consent)

I do *NOT* give my consent for the emergency medical treatment of my child or myself. In the event of illness or injury requiring emergency treatment, I wish the St.Clairsville Department of Parks & Recreation authorities take no action to:

Signature:_____ Date: _____