Lake Martin Trailblazer Registration Form

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

Youth's First Name	Middle Initial	Last Name	Phone Number

Address	City	State	Zip Code

Sex:	Date of Birth	Name of School	Grade	Email

Membership Status: New Member _____ Returning Member_____ PROGRAM NAME: **WANDERERS PROGRAM** Group Name_____

Father or guardian name_____

Address (if different from child) _____

_____

Phone#_____

Employer _____

Employer # _____

Occupation _____

Mother or guardian name_____

Address (if different from child) _____

_____

Phone # _____

Employer _____

Employer # _____

Occupation_____

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Emergency Contact:	Emergency Contact
Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Relationship: _____	Relationship_____ **Persons authorized to pick up my child:**
Name: _____	**Name:** _____
Relationship: _____	**Relationship:** _____

Persons NOT authorized to pick up my child:

Name: _____ **Relationship:** _____

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The following information is used for statistical purposes only

Ethnic/Racial:	Total # in family (living in household)	Household Income:	Disabilities:
✈ Asian ✈ Black/African -- American ✈ Hispanic ✈ Multi Racial ✈ Native American ✈ Native Hawaiian/Pacific Islander ✈ White/Caucasian	✈ 2-3 ✈ 4-5 ✈ 6-8 ✈ 0ver 8	✈ Under $15,000 ✈ $15,001 - $25,000 ✈ $25,001 - $40,000 ✈ $40,001 - $55,000 ✈ $55,001 - $70,000 ✈ Over $70,000	✈ Physical_____ ✈ Developmental_____ ✈ Other_____ ✈ Other information you would like to share_____

Parents we NEED you! I am interested in the following:	Photo:
✈ Joining the Board ✈ Volunteering when needed ✈ Participating in Fundraising ✈ Drive for outings ✈ Arrange for trips or special events ✈ Other: _____	You have my permission to use photographs in which my child (or ward) appears in for Lake Martin Trailblazers publicity: this includes, social media, websites, and print media. ✈ Yes ✈ No Signature_____ Date_____

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Child's Name_____ Parent Name _____

Address_____ Phone_____

Name of Family Physician _____ Family Dentist_____

Name of any known allergies: Food_____ Drugs_____ Plants_____ Animals_____

Insects_____ Other_____ Explain reaction and indicate medication used_____ (Any medication needed for allergies should be with child at all activities)

Type of medical insurance _____ Contract #_____ Employer through which insurance is received _____ If there is any question about activity restriction, attach a statement from physician indicating restrictions and noting any pertinent recommendations.

Emergency Contact _____ Phone_____

GENERAL RELEASE AND MEDICAL RELEASE

I, _____, being fully aware of the potential risk and dangers of participation in program activities, do voluntarily participate and take part in said program of activities recognizing and acknowledging the risk of injuring myself or others for whom I may be legally responsible. In consideration of having the opportunity to be a part of program activities with Lake Martin Trailblazers, I do hereby fully release and discharge Lake Martin Trailblazers, its employees, agents, office managers, members, related companies, volunteers, servants, successors, and assigns from any and all claims, demands, rights, causes of action, damages, expenses and compensation of every kind whatsoever and including, without limitation, all liability for damages or injury of every kind, nature or description, including contagious or infectious disease, whether foreseen or unforeseen, known or unknown which may hereafter, arise from or out of injuries and damages occurring during said programs, to include but not be limited to applicable periods of class and sojourn. In the event I am injured, I hereby authorize and consent to any basic first aid treatment and / or x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered under the general or special supervision and on the advice of licensed physician, surgeon, anesthesiologist, dentist, or other qualified medical personnel acting under their supervision should any medical treatment become necessary during the aforesaid period. I do further authorize and appoint Program Staff with full power of attorney to exercise and authorize the consent herein for such treatment at any hospital or other medical institution whose services are needed for such proper care and treatment. I do hereby release and discharge Lake Martin Trailblazers and Program Staff from any and all liability resulting from the reasonable exercise of said power of attorney.

Participant Signature_____ Parent or Guardian Signature_____

Date_____ Date_____

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