



gwinnettcountry parks & recreation Camp Registration Form

Please use the following instructions when completing this form:
1. One participant per form.
2. Must be completed by parent or legal guardian and accompanied with full payment.
3. Camp must make minimum enrollment in order to operate.

Program Code	Program Location

**gwinnettcountry
parks & recreation**

Camper Information:

Participant Name: _____

D/O/B: _____ Male Female

Address: _____ City: _____

State: _____ Zip Code: _____

Grade Next Fall: _____ School Next Fall: _____ Gwinnett Resident: Yes No

Additional Information:

Known Allergies (include food, medication, latex, etc.): _____

Recent Illnesses or Injuries (last 6 months): _____

Recent Prescription medications (last 6 months): _____

List all special circumstances, emotional or physical conditions regarding your child. Failure to disclose information or conditions may result in your child being disallowed registration or removed from participation. If removed due to failure to disclose, no refund or transfer of fees is allowed. If accommodation requests are made less than two weeks in advance, Gwinnett County Parks & Recreation will make every effort to meet the request. If we are unable to meet the request in time, GCPR reserves the right to limit or disallow registration for the requested session. However, the participant will be eligible to register for another program later in the session. _____

Parent/Guardian Information:

Parent/Guardian #1 (that lives with camper/same address)

Name: _____

Home Phone: _____ Other Phone 1: _____ Other Phone 2: _____

Email Address: _____

Parent/Guardian #2

Name: _____

Home Phone (if different than camper): _____

Address (if different): _____ City: _____ State: _____ Zip Code: _____

Other Phone 1: _____ Other Phone 2: _____ Email Address: _____

Pick-Up/Drop-Off/Emergency Contact list

You authorize this list of people to act as a caregiver and pick-up/drop-off your child and if needed be contacted in an emergency situation. Parents/Guardians will remain the first point of contact in an emergency. Photo I.D. may be requested upon sign-out.

Name	Relationship to Participant	Contact Number

LIABILITY RELEASE, INDEMNIFICATION AND MEDICAL AUTHORIZATION

I am aware of the nature of this activity and I hereby assume responsibility for my child _____, to participate in the Summer Camp Program. I understand that such participation may include being photographed for publicity purposes and riding in Gwinnett County vehicles to activities which are not located on Gwinnett County property. I understand that participation in the Summer Camp Program can result in bodily injuries to my child, including but not limited to, contusions, cuts, scrapes, head and/or dental injuries and broken and/or sprained limbs. I will not hold Gwinnett County and/or its elected and appointed officials, officers, employees, agents and volunteers responsible in the case of accident or injury as a result of child's participation in the Summer Camp Program. I further agree to indemnify, defend and hold harmless Gwinnett County, its elected officials, officers, employees, agents, and volunteers from any and all claims arising from participation in the Summer Camp Program and its related activities. Such indemnification shall include, but not be limited to, liability settlements, damage awards, costs and attorney's fees associated with any such claim. In situations which are true emergencies and only when I cannot be reached immediately, I authorize a representative of Gwinnett County, Georgia to obtain immediate medical care and I consent to the hospitalization of, the performance of necessary diagnostic tests upon, the use of surgery on, and/or the administration of drugs to my child if an emergency occurs when I cannot be located immediately. I will not hold Gwinnett County and/or its elected and appointed officials, officials, employees, agents and volunteers responsible for injuries or damages sustained by my child as a result of the immediate medical care. I understand that I am responsible for payment of medical expenses.

Name of Insurance Company: _____ Policy Number: _____

Child's Physician/Clinic: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Signature of Parent/Guardian: _____

Date: _____