Program Registration and Waiver Form
Pickfair Community Center
10904 Pickfair Dr.
Austin, Texas 78750
Phone:512-401-8119

A. Youth Waiver (please fully complete waiver with a pen):

Participant Name:_____

Birthdate:_____ Age:_____ Gender: ☐ Male ☐ Female

B. Completion required by all participants. Primary and Secondary must reside at same Household address. If not, complete box D

Household Mailing Address:_____ Zip:_____

Household Home Phone:_____

Household Primary Name:_____

Birthdate:_____ Gender: ☐ Male ☐ Female Email: _____

Primary Cell Phone*:_____ Provider: _____ Primary Work Phone:_____

Household Secondary Name:_____

Birthdate:_____ Gender: ☐ Male ☐ Female Email: _____

Secondary Cell Phone*:_____ Provider: _____ Secondary Work Phone:_____

C. Completion required by all participants. List any Emergency Contacts other than Household members listed above.

Emergency Contact Name:	Relation:	Home Phone:	Work Phone:	Cell Phone:	Allowed to Pick Up?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

D. Only complete this box if a Youth Participant resides within two separate Households.

Household Mailing Address:_____ Zip:_____

Household Home Phone:_____

Household Primary Name:_____

Birthdate:_____ Gender: ☐ Male ☐ Female Email: _____

Primary Cell Phone*:_____ Provider: _____ Primary Work Phone:_____

Household Secondary Name:_____

Birthdate:_____ Gender: ☐ Male ☐ Female Email: _____

Secondary Cell Phone*:_____ Provider: _____ Secondary Work Phone:_____

E. Completion required by all participants.

Medical Care Information

1. Any known allergies to food/drugs, insect stings, poison ivy/other plants, etc.? {Yes_____} {No_____} Please Specify:_____

2. Any known existing illnesses? {Yes_____} {No_____} Please Specify:_____

3. Please list any physical condition that could restrict activities or have a need requiring special care in order to participate in program/activity. _____

4. For Youth & Children Only : Does Participant require prescription medication during program hours? Program must exceed 1 hour. {Yes_____} {No_____} If yes, please complete a Medication Authorization form.

Personal Information Privacy Policy

We collect personally identifiable information, like names, postal addresses, email addresses, etc., when voluntarily submitted by our visitors. The information you provide is used to fulfill your specific request. This information is only used to fulfill your specific request, unless you give us permission to use it in another manner, for example to add you to one of our mailing lists. {email opt out?_____}

Image Release Waiver

I hereby consent to allow usage of photographs and video taken during this program and at our sites for publicity purposes in printed materials, and on our website. Photographs remain the property of the City of Austin Parks and Recreation Department. If you do not want to allow photos or videos, then please initial. {opt out?_____}

Accessibility Accommodation Request

The City of Austin is proud to comply with the Americans with Disabilities Act. If you require assistance for participation in our programs or use of our facilities, please call 512.974.3910. Do you require accommodations? {Yes_____} {No_____} (Optional)

Standards of Care Notification

Children's programs/activities supervised by Parks and Recreation Department and requiring enrollment/registration in order to participate are not licensed by the state, but follow standards of care adopted in the City of Austin Ordinance No. 20110324-060. A copy is available and posted at each site.

Release of Liability

In consideration of participant being allowed to participate in the registered class(es) or program(s), the undersigned hereby releases the City, its employees and agents, from any action, claim or demand for personal injury or property loss arising from or due to any negligent act or omission of the City, its agents or employees. This release shall have no effect with regard to damages caused by the City's gross negligence. In the event the City or a volunteer provides transportation for the registered participant, this waiver and release shall extend to and release the City employee driver from any and all liability. Permission is given for any emergency medical treatment, operation or anesthesia which might become necessary. I agree to be responsible for the expense of medical treatment or service.

Please Print Name: _____

Signature: _____ Date: _____