

PERMISSION SLIP TO PARTICIPATE IN CHARLESTOWN RECREATION ACTIVITY

NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_  
(Print) (Circle one)  
Mailing Address: \_\_\_\_\_ **Shirt Size: Youth S, M, L, XL or Adult S, M, L, XL**  
Phone # \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Activity: \_\_\_\_\_ Today's Date: \_\_\_\_\_

We the parents of the above named candidate, hereby give our approval for his/her participation in activities Sponsored by the Charlestown Recreation Department. We understand that there will be supervision, but that the Participant is responsible for his/her conduct as well. We acknowledge that the adults who are supervising the activity Reserve the right to contact us, the parent/guardian, if the participant is acting in an unsafe and/or inappropriate Manner. We also understand that if the uniform issued to participate in the program is asked to be returned, and is not Returned to the coach /Recreation Dept in reasonably good condition, we will be charged a replacement fee of \$20.00.

We understand that there exists a possibility of injury. We do hereby waiver, release, absolve, indemnify, and agree To hold harmless the organizers, sponsors, supervisors and participants, except to the extent, and in the amount, covered By liability or accident insurance. We approve any emergency treatment necessary if he/she is injured while Participating in an activity.

PARENTS' SIGNATURES: \_\_\_\_\_ DATE: \_\_\_\_\_  
\_\_\_\_\_ DATE: \_\_\_\_\_

(To be kept on file with Charlestown Rec Dept)

(To be in possession of the coach for any such emergency)

PERMISSION FOR EMERGENCY MEDICAL TREATMENT

In the event of an emergency requiring medical attention, I hereby grant permission to a physician or other hospital personnel to attend my son/daughter. I expect and understand that every effort will be made to contact me in order to receive my specific authorization before any further treatment or hospitalization is undertaken.

NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_  
Parent's (Mother) \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_  
(Print) (Father) \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

**Email address to be used by the coach:** \_\_\_\_\_

If unable to contact above person(s), please notify:

Name(s) \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_  
\_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_

State any medical problems or conditions your child has had, such as asthma, heart trouble, diabetes, epilepsy, allergies, etc.:

Insurance Company \_\_\_\_\_ Family Health Ins. No. \_\_\_\_\_

**If no personal provider is listed, use the Charlestown Recreation Insurance provider:  
Clark Mortenson Agency 826-7781**

PARENTS' SIGNATURES: \_\_\_\_\_ DATE: \_\_\_\_\_  
\_\_\_\_\_ DATE: \_\_\_\_\_