



REGISTRATION FORM

Is this the first time you are registering for programs at the VHPD? No Yes – if yes, complete back of form

Family Last Name _____ Primary Phone (_____) _____

Work Phone (_____) _____ Secondary Phone (_____) _____

Address _____ Email _____

City _____ Zip _____ School District #73: Yes No

Emergency Contact _____ Relationship _____

Emergency Phone #1 (_____) _____ Emergency Phone #2 (_____) _____

I agree to the waiver on the back of this form. Signature _____ **Date** _____

Participant _____ **Age** _____ **Birthdate** _____ **Gender** _____ **Grade (Fall '19)** _____

Check if this participant needs any accommodations, in accordance with The American with Disabilities Act, to effectively participate in any of these activities.

| CODE | PROGRAM | FEE | | OFFICE USE | | |
|------|---------|-----|--|------------|-----------------|-------------|
| | | | | R / W | Initials: _____ | Date: _____ |
| | | | | R / W | Initials: _____ | Date: _____ |
| | | | | R / W | Initials: _____ | Date: _____ |
| | | | | R / W | Initials: _____ | Date: _____ |

Participant _____ **Age** _____ **Birthdate** _____ **Gender** _____ **Grade (Fall '19)** _____

Check if this participant needs any accommodations, in accordance with The American with Disabilities Act, to effectively participate in any of these activities.

| CODE | PROGRAM | FEE | | OFFICE USE | | |
|------|---------|-----|--|------------|-----------------|-------------|
| | | | | R / W | Initials: _____ | Date: _____ |
| | | | | R / W | Initials: _____ | Date: _____ |
| | | | | R / W | Initials: _____ | Date: _____ |
| | | | | R / W | Initials: _____ | Date: _____ |

Method of Payment: Cash Credit/Debit Card Check # _____ **H/H credit** _____

Total Paid: \$ _____ All credit cards are charged & cash and checks are deposited as they are received
 Make checks payable to: Vernon Hills Park District

I authorize the Vernon Hills Park District to automatically charge the credit/debit card listed below for program registrations offering a payment schedule - check applicable program(s): Preschool Swim Team Dance

Charge To: Visa MasterCard Discover Debit
Account Number _____ **Exp Date** _____
Cardholder Name _____ **CVV** _____
Authorized Signature _____ **Amt \$** _____

Medical Conditions

Please note any allergies, special medications, or additional conditions which may affect participation.

Name: _____

Comments: _____

All program cancellations must be made in writing ten working days before the start of the program. A \$5 service charge will be assessed per registrant per program.

OFFICE USE: Contact information verified in Max Galaxy _____ (initials)

