



Member Registration

PRINT CLEARLY

-- Please have identification ready to show --

Name (First & Last) _____

Date of Birth _____ Driver License # _____ Gender M E

Email _____ Phone # (_____) _____ - _____

Address

Street _____ Apt. # _____

City/State/Zip _____

Emergency Contacts

Name _____ Relationship _____

Phone # (_____) _____ - _____

Name _____ Relationship _____

Phone # (_____) _____ - _____

Liability Statement:

Participation in all fitness and recreation programs is on a voluntary basis. Manchester Local School District will not be liable for any injuries, damages, or other such losses which individuals may incur while using fitness and recreation facilities or participating in fitness and recreation programs.

I, the undersigned, specifically assume all risk of injury, damages, or other such losses while using fitness and recreation programs or participating in any program, exercise, or activity at the Manchester Educational and Activity Center or on district property. I waive any and all claims against Manchester Local School District, its Board of Education, officers, agents, and employees for any such injuries, damages, or other such losses.

X _____ Date _____ / _____ / 2019
Signature (Parent/Guardian if under age 18)

Print (if not listed as Member Name)

Medical Questionnaire

Note: The information contained below will only be used to better tend to you in the event of an emergency. This information will remain confidential at all times.

Please check the boxes next to any of the following conditions you now have, or have experienced in the past:

- Heart attack Stroke Coronary bypass Elevated cholesterol
- Diabetes Chest discomfort Hypertension Asthma Epilepsy
- Heart palpitations Heart murmur Fainting Bursitis

Please briefly explain any checked boxes or other medical conditions our staff should be made aware of:

Have any of your blood relatives had any of the above conditions? Yes No

If Yes, please briefly explain:

When was your last physical examination? _____

Please ask for a medication slip to list any medications you are consuming.

Office Use Only

Payment ID: _____

AFV: Y or N
(Copy in file)

Household Members
