

City of Seaside Registration Form

Head of Household

(circle one)

Last Name: _____ First Name: _____ Male/Female

Resident Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: (if different) _____

Home Phone: _____ Work/Cell Phone: _____

Emergency Contact: _____ Emergency Number: _____
 Name Relationship

E-mail Address: _____

Special Instructions: _____

Participants Name	M/F	DOB	Activity Name	Activity #	Fee
			SELF DEFENSE CLINIC	111007-01	
Total:					

Method Of Payment

Check/Money Order (Make Payabel to **City of Seaside**, 986 Hilby Ave., Seaside, CA 93955)

MasterCard Visa American Express Card #:

Credit Card Signature: _____ Exp. Date: _____

Medical Consent and Liability, Indemnity and Participation Agreement

In consideration of my own and/or the above named individuals) participation in the programs listed above, I voluntarily release the City of Seaside, their officers, agents, employees and volunteers from any and all liability for injuries or death, or property damage resulting from or in any way connected with my and/or the individuals) named above participation in the program. Additionally, as myself and/or as parent and/or guardian of the individuals) named above, I do forever release and hold harmless and indemnify the City, their officers, agents, employees and volunteers from all claims or rights of action for damages which myself and/or the above named individuals) has or may hereafter have, resulting in anyway connected with myself and/or the individuals) named above participating in this program, either before or after the individual named above reaches their age of majority. I understand that this waiver and release is applicable even though the negligent activities of the City, their officers, agents, employees or volunteers may have caused or contributed to the injury or death or property damage.

In consideration of my own and/or the above named individuals) participation in the programs listed above do hereby agree to allow the individuals) named above to participate in the aforementioned activity and authorize the program directors and/or instructors as agents for the above signed to consent to medical, surgical and dental examination, in addition to any and all other treatments that may be deemed necessary by medical personnel. It is further understood that this Agreement is binding on my heirs and assigns, as well as those of the individuals) named above. I agree that pictures taken during program hours may be used for all future promotional purposes and hereby grant permission to the City to use my own or the above named individuals picture in the City's publications and the City's internet webpage. I further agree on behalf of myself and the above named individual to release and discharge the City, its officers, employees, agents, and volunteers from any and all claims or causes of action arising out of the photograph, name, image or likeness. In the absence of a signature below, payment of fees and participation in the program shall constitute acceptance of the conditions set forth in the release. I agree to return upon request equipment issued to the above participants in as good condition as when received except for normal wear and tear. The City of Seaside will not provide health and/or accident insurance for program participants.

I HAVE READ THIS MEDICAL CONSENT AND LIABILITY, INDEMNITY AND PARTICIPATION AGREEMENT, FULLY UNDERSTAND IT AND SIGN IT FREELY AND VOLUNTARILY WITHOUT INDUCEMENT
For Tax Purposes: Our Tax ID Number is 94-6022439

Signature: _____ Print Name: _____

Check all that apply: Participant Parent Legal Gardian Date: _____