MAYVILLE TAG CENTER
PROGRAM REGISTRATION FORM

1700 Breckenridge St
Mayville WI 53050
920-387-7988

(Guardian)
First Name: _____ Last Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Birth Date: _____ Email: _____

Participants Name	Program Name	Day/Time	Grade	Birth Date/Age	Fee

(**Circle T-Shirt size if offered**: YS YM YL AS AM AL) Total Fees: _____

List any Medical Problems, Allergies Etc. _____

LIABILITY WAIVER: All registrants are required to sign the following release. Parents or guardians must sign for minors. I the undersigned do hereby agree, or agree for the above named registrant for whom I am the parent or guardian, to participate in the activity and am aware of and understand that there may be risks and hazards inherent with participation in this activity. I affirm that I, or the minor registered for this activity, am doing so as a voluntary participant. In consideration of my participation or participation of the minor I do hereby agree to release, waive, above, indemnity on behalf of myself or minor, my/his/her family, my/his/her heirs and my/his/her assigns the **City of Mayville**, its employees, officers, agents and sponsors from liability from injury, death or loss suffered by me or the minor in any and all present and future claims, liabilities, damages or right of action directly or indirectly resulting out of participation in the activity, using the facilities, or in engaging in any activities incidental thereto during the duration of the scheduled program, which result from ordinary negligence of the City of Mayville, its employees, officers, agents, and sponsors. **The City of Mayville does not provide insurance to participants in recreational activities and I assume full responsibility for any and all injuries or damages which may occur to me while participating. MEDICAL EMERGENCY RELEASE WAIVER FOR MINORS:** In the event of a medical emergency I authorize the Mayville Parks and Recreations Department and or TAG Center Staff to obtain medical treatment for my son/daughter or minor for which I am guardian.

There will be a $5.00 late fee per child if you sign up after the registration deadline.
There is a $35.00 service fee for all bad checks.

Parent/Guardian Signature: _____ Date: _____

****

OFFICE USE:

Cash: _____ Check #: _____ Credit Card: _____

Date Paid: _____ Cashier Initials: _____ **Entered**