

Franklin County Parks & Recreation Department

Program Registration Form

TO REGISTER COMPLETE THIS FORM AND SUBMIT WITH FULL PAYMENT

Make Check Payable To: Franklin County Parks and Recreation

Mail To:

Franklin County Parks and Recreation
62 West River Rd.
Louisburg, NC 27549

Phone: (919) 496-6624
Fax: (919) 496-7656
Email: recreate@franklincorec.com

Name of Program: _____

Participant's Name: _____ Gender: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____
Number & Street, P.O. Box, etc.

Residence Address: _____ City: _____ State: _____ Zip: _____
(If different from mailing address)

Home Phone: _____ Work Phone: _____ Other Phone: _____

*Medical Conditions: _____ Doctor's Name: _____
*Attach additional sheets/information if necessary

Participant's School: _____ Grade: _____

Area where you want to participate (check one):
(If you have a 1st and 2nd choice place numbers by city)

Bunn: _____

Edward Best: _____

Franklinton: _____

Louisburg: _____

Youngsville: _____

No Preference: _____

Birthdate: _____ *Age: _____ Height: _____ Weight: _____
(*Age as of cut-off date for certain programs)

T-Shirt Size: _____YM (26-28" Chest) _____AS (34-36" Chest) _____AL (42-44" Chest) _____AXXL (26-28" Chest)
(Check one) _____YL (30-32" Chest) _____AM (38-40" Chest) _____AXL (46-48" Chest) _____AXXXL (54-56" Chest)
(Y=Children's Sizes, A=Adult Sizes, S=Small, M=Medium, L=Large, X=Extra)

Father's Name: _____ Father's Work Phone: _____

Mother's Name: _____ Mother's Work Phone: _____

Can You Help: Coach Team Sponsor Team Other (specify) _____

Waiver and Agreement

I hereby release Franklin County, its' employees and agents from responsibility for injuries (physical or otherwise) incurred during program activities. (If this registration is for a sports program), I understand that participation in sports can cause injury and that injuries are a natural part of the game. I agree to abide by departmental rules and regulations that govern the program above as indicated. In the event of a medical emergency, I hereby give permission to medical personnel to provide necessary medical treatment to me or the minor child listed above as participant. I certify that all information contained in this form is true and correct to the best of my knowledge and belief.

Signature: _____ Date: _____

For office use only:

Date Rcvd: _____

Amount Rcvd: _____

Received By: _____

Form of Pay: _____

Receipt #: _____

Payment: Enter Franklin County Resident fee amount here \$ _____
Enter Non-resident fee amount here \$ _____
Enter Special or Additional fee amounts here \$ _____
Enter Total Amount Enclosed here \$ _____