

**SORRY- WE DO
NOT ACCEPT
MAIL-IN
REGISTRATION**

CITY OF LAWNSDALE
Community Services Department
14717 Burin Avenue
Lawndale, California 90260
Phone (310) 970-3270 / Fax (310) 676-9471



ACTIVITY / CLASS REGISTRATION
Name of Activity/Class _____

Participant's Full Name _____ Age of participant if under 18 _____

(PLEASE PRINT)

Payee's Full name _____ Relationship to Participant _____

Address of Participant _____ City _____ Zip _____

Parent/Guardian Phone (H) _____ (W) _____ (P/C) _____

Jersey/Shirt Size (if Applicable): (YS) (YM) (YL) (AS) (AM) (AL) (AXL) You will receive shirt nearest to requested size.

Under the supervision of the City of Lawndale, Community Services Department, I hereby agree to indemnify the CITY OF LAWNSDALE, its officers/agents, representatives and/or employees from any loss and/or liability, including expenses and costs, that may result from any death or injuries or damages to property that may be sustained while participating in any activity connected with said program including but not limited to travel to and from that activity, whether such death or damage to property is caused by the negligent act or omission of the CITY OF LAWNSDALE, its officers/agents, representatives and/or employees, or any other cause. Pursuant to California Civic Code Section 25.8, I hereby authorize any adult employee to the CITY OF LAWNSDALE, into whose care has been entrusted to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to under the general or special supervision and upon advice of a physician and surgeon licensed under the Medical Practice Act, or to consent to an x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to by a dentist licensed under the Dental Practice Act.

PLEASE LIST ANY MEDICATIONS TAKEN BY THE ABOVE NAMED PERSON ON THE DAY OF THE ACTIVITY (this information is for emergency use only)

Medication Taken _____

Allergies _____

IN THE EVEN THAT THE PARENT /LEGAL GUARDIAN CANNOT BE REACHED, PLEASE CONTACT:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

If neither of the above can be reached, or time does not permit, I as parent/legal guardian, give my consent for the City of Lawndale staff to obtain emergency medical treatment required for the immediate care of my child.

Signature of Parent/Legal Guardian _____ Date _____

Home Address _____ City _____ Zip Code _____

FOR OFFICE USE ONLY

Receipt # _____ Amount Paid _____ Received by _____
