

WILLIAMSBURG RECREATION DEPARTMENT SPRING FLAG FOOTBALL
939 SOUTH HIGHLAND, PO BOX 596
WILLIAMSBURG, IA 52361
(319)668-1636
rec@iowatelecom.net

It is time to start planning our **Spring Flag Football** program. Practices will begin the week of March 22nd with games running April 3rd-April 24th. Sign-up forms may be mailed or dropped off to the above address. **Deadline** for registration is **March 8th**. All mailed registration forms must be postmarked no later than March 8th.

CHILD'S NAME _____ DATE OF BIRTH _____ / _____ / _____
(Last Name) (First Name)

PARENT'S NAME _____ BOY/GIRL (**circle**) GRADE SPRING: _____

MAILING ADDRESS _____ CITY, STATE, ZIP _____

HOME PHONE _____ / _____ / _____ WORK PHONE _____ / _____ / _____

EMAIL ADDRESS _____

PROGRAM FEES - \$30.00 per child

THERE WILL BE A **\$20.00** SURCHARGE FOR ENTRIES RECEIVED **AFTER** THE DEADLINE.

League Breakdown (2010 Spring Grade): Please circle one

3rd – 4th

5th – 6th

(Again this year the High School coaching staff will be running the league at the Rec Center.)

Shirt Size (circle one):

Youth Medium (10-12)

Youth Large (14-16)

Adult Small

Adult Medium

Adult Large

Adult XL

If you have more than one child playing in the same league, please list their name so that we can assure them on the same team together.

SIBLING _____ **SPRING GRADE** _____

I, _____, give my child, _____, permission to participate in the programs set forth by WILLIAMSBURG RECREATION DEPARTMENT. I realize that these programs are run by volunteers, and will not hold anyone personally liable in the event of accidental injury of my child.

Date: _____ Signed: _____

(Please complete release form on back of this page)

Parent or Guardian Signature

THIS PAPER MUST BE FILLED OUT AND SIGNED BEFORE YOUR CHILD MAY PARTICIPATE.

EMERGENCY TREATMENT RELEASE FORM

PARTICIPANT'S NAME _____ BOY OR GIRL (circle one please)

PARENT'S NAME _____ HOME PHONE : (_____) _____ - _____

ADDRESS _____ TOWN _____ ZIP _____

EMAIL ADDRESS _____

FATHER _____ PLACE OF EMPLOYMENT _____ PHONE: ____/____/____

MOTHER _____ PLACE OF EMPLOYMENT _____ PHONE: ____/____/____

FAMILY PHYSICIAN _____ CITY _____ PHONE: ____/____/____

SPECIFY MEDICAL ALLERGIES, CHRONIC ILLNESSES OR OTHER CONDITIONS:

OTHER LOCAL CONTACT IN CASE OF EMERGENCY:

NAME: _____ PHONE: ____/____/____

NAME: _____ PHONE: ____/____/____

As a parent and/or guardian, I do hereby give my permission to an authorized representative of the Williamsburg Recreational Department to obtain professional medical attention for my child in case of injury or illness; if I cannot be located. I understand that **I am** responsible for all cost involved.

I do hereby authorize treatment by a qualified and licensed physician of the following minor in the event of a medical emergency which, in the opinion of the attending physician, if delayed. This authority is granted only after a reasonable effort has been made to reach me.

NAME OF MINOR CHILD _____

THIS RELEASE FORM IS COMPLETED AND SIGNED OF MY OWN FREE WILL WITH THE SOLE PURPOSE OF AUTHORIZING MEDICAL TREATMENT UNDER MEDICAL EMERGENCY CIRCUMSTANCES IN MY ABSENCE.

SIGNED: _____

RELATIONSHIP-CIRCLE ONE: FATHER MOTHER LEGAL GUARDIAN