



JCPRD PROGRAM REGISTRATION FORM

Return completed form with fee.

Make checks payable to: JCPRD

Mail to: Registration Office (Bldg. D) 6501 Antioch Road, Shawnee Mission, KS 66202

NOTE: There is a \$30 service charge on all returned checks.

Office use Only:
Payment: CA CK MC VS DS
Registrar: _____
Date: _____

(PRINT) Participant's Name	Birth Date	Program Code	Program Title	Date	Day	Time	Fee
	/ / #						
	/ / #						
	/ / #						
	/ / #						
	/ / #						
	/ / #						
	/ / #						

JCPRD is committed to making reasonable accommodations as required by the Americans With Disabilities Act. Requests must be made two weeks or ten working days prior to the start of the program. Please indicate what accommodations are needed: _____

WAIVER STATEMENT: The undersigned states that he/she understands that the Johnson County Park & Recreation District is not and shall not be responsible for or liable for any illness, or injury to person or damage to property resulting from the program in which the participant is enrolling or being enrolled or from his/her participating in said program, and the participant and the undersigned, if the participant is a minor or under other legal disability, hereby forever releases and holds harmless the said Johnson County Park & Recreation District, its employees, agents and representatives from any and all claims of any kind that the participant, or the undersigned or their respective heirs, executors, administrators, or assigns may have or claim to have resulting from participation in said program. **NOTICE:** By enrolling in this program you hereby acknowledge the Johnson County Park & Recreation District can and may photograph and/or video tape program participants and then use such images, without payment or any other consideration, for purposes of publicizing district parks, facilities, programs or services, or for any other lawful purpose. (Registration is invalid without signature.)

I have read and understand the waiver statement.

X _____ Signature _____ Home phone# _____ () _____ Work phone# _____ Ext.# _____

Mailing Address: _____ Street _____ Apt.# _____ City _____ State _____ Zip _____

Email address: _____

Charge all fees to MC VS or DS Name as Printed on Card: _____

Card #: _____ Expires: _____

Billing Address: _____ Street _____ Apt.# _____ City _____ State _____ Zip _____