



**Kent County Department of Parks and Recreation**  
 PO Box 67, Worton MD 21678, p(410)778-2083, f(410)778-4602, KentParksAndRec.org  
**Leaders Club – Registration Form**

*“Striving for success without hard work  
 is like trying to harvest where you haven't planted.”*

**PARTICIPANT INFORMATION PRINT**

Participant Name \_\_\_\_\_ Grade NEXT year 7 8 9

Site (Circle ONE)    Chestertown    Galena    Rock Hall    Worton    T-shirt Size (XS – XXL) \_\_\_\_\_

Birth Date (M/D/Y) \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Male / Female

Mailing Address \_\_\_\_\_ City / State / Zip Code \_\_\_\_\_

Mother / Guardian Name \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Father / Guardian Name \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

**LEADERS CLUB RELEASE/WAIVER**

*I hereby give permission for my child to attend and be transported to all trips and activities sponsored by the Kent County Department of Recreation. In consideration of the Recreation Department's acceptance of my child in this program, I agree to release and discharge Kent County, its employees, and agents from any injuries sustained by my child as a result of participation in this program. I agree to indemnify and hold harmless, Kent County, its employees, and agents against any liability incurred as a result of such injury or loss. It is understood and agreed that Kent County, its employees and agents cannot be responsible for any aggravation or injury caused as a result of a pre-existing physical defect; including but not limited to allergies. The Parks and Recreation Department will be notified of any such defects or sensitivities in writing prior to enrolling in this program. In addition my signature gives permission for my child to be photographed or video taped for the purposes of archives and advertising.*

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**METHOD OF PAYMENT OFFICE USE ONLY**

YEAR FEE \$300.00    CHECK # \_\_\_\_\_    CASH \_\_\_\_\_    Scholarship Application Received \_\_\_\_\_

Scholarship Award    FULL    PARTIAL    Amount Due \_\_\_\_\_    Award Notification Sent \_\_\_\_\_

Payment Received \_\_\_\_\_    Welcome Sent \_\_\_\_\_

Date	Staff Initials
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**Kent County Department of Parks and Recreation**  
 PO Box 67, Worton MD 21678, p(410)778-2083, f(410)778-4602, KentParksAndRec.org  
**Leaders Club – Health History Form**  
 To assure the safety of your child in our programs this health history is to be completed in its entirety and signed by the parents/guardians of the participant.

**PARTICIPANT INFORMATION**

Participant Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ F/M \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent/Guardian Full Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_

**EMERGENCY CONTACTS**

\*Please list two emergency contacts, other than parent/guardian.

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy/Group # \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

**GENERAL HISTORY**

\*If participant is not enrolled in a Maryland school, a copy of his/her CURRENT immunization record or medical contraindication or religious objection must accompany this health form.

Maryland School Participant Attends \_\_\_\_\_ City \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_ Date of Last Tetanus Vaccine \_\_\_\_\_

List any recent or continuing health problems \_\_\_\_\_

List any physical or learning disabilities \_\_\_\_\_

List any drug/food allergies \_\_\_\_\_

List any current medications \_\_\_\_\_

Has participant experienced any of the following?

Type	Y	N	Date	Type	Y	N	Date	Type	Y	N	Date
Eating Disorder				Menstruation Problems				Headaches			
Sleeping Disorder				Bowel/Bladder Disorder				Asthma			
Posture Problems				Eye Problems				Diabetes			
Dental Problems				Wear Glasses or Contacts				Anemia			
Skin Problems				Hearing Difficulties				Speech Problems			

The above health history is correct to the best of my knowledge and the person herein described has permission to engage in all described activities except as noted. Authorization for treatment: I hereby give permission for the medical personnel selected by the program administrator to order x-rays, routine tests, treatment, and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the program administrator to secure and administer treatment, including hospitalization, for my child as named above. The completed forms may be photocopies for trips away from the program site.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_