

**Long Branch Area YMCA
Adult Program Registration Form
(ages 18 and over)**

Participant's Name:	Birthdate:	Gender: M F
Home Address:	Y-member: Y N	
City, State, Zip:	Home Phone:	
Cell Phone:	Work Phone:	
Contact E-Mail:		
Preferred method of contact in case of cancellation:(circle one) Phone – Hm/Wrk/Cell/E-mail/other		
Emergency Contact:	Relationship:	Phone:
Medical/Physical concerns or limitations:		

I consent to participate in Long Branch Area YMCA programs. I understand that there is risk of injury, as there is with most activities. Injuries obtained could be very minor, such as bruises or sprangs, but could also be more serious.

It is understood that the Long Branch Area YMCA coaches and staff do not insure against, nor accept responsibility for personal injury or property loss or damage to the participant which may be sustained as a result of participation in YMCA programs. The above participant is responsible for medical care, treatment, and insurance.

In consideration for the above person to be allowed to participate in YMCA programs, I agree to assume the risk of such programs and agree to release the YMCA and all staff from any claims, suits, losses or related causes or action for damages, including, but not limited to such claims that may result from injury or death, accidental or otherwise, during or arising in any way from YMCA programs.

Medical Clearance: If I answer “yes” to any of the following questions, I understand that it is my responsibility to complete an **Informed Consent Waiver** which may be obtained from the YMCA office.
 1. Has a doctor ever informed you that you have high blood pressure? 2. Have you ever had a heart attack, heart surgery or any type of heart problem? 3. Do you have any serious orthopedic problems? 4. Are you pregnant? 5. Is there any reason why you believe you should not be engaged in exercise?

Permission for Medical Treatment

If the undersigned has doubts about the physical condition of the above participant, a physical examination by a physician is recommended. In addition, the undersigned, hereby authorizes any first aid or medical treatment deemed necessary in the case of emergency for participant and gives permission for emergency treatment, x-rays, or surgery as recommended by attending physician.

I assume full financial responsibility for any and all medical care. I understand and agree to the responsibilities of this document.

_____/_____
 Signature of Participant / Printed Name of Participant Date _____