Crestwood Hills Class Registration Form

Be sure to fill out and submit this form for WALK-IN and online registration.

Please fill out registration form completely.

Please make personal check or money order payable to:

"City of Los Angeles Department of Rec. and Parks"

Please Print Clearly and fill out this form completely.

RW:_____ **Staff Int.:**_____

(For Office Use Only)

Parent/Gaurdian Last Name_____First Name_____

Address:_____City_____Zip_____

EMAIL:_____Phone#(____)_____

EMERGENCY CONTACT: Name_____Phone#(____)_____

Class Title	Day/Time	Fee Amount	Participant Name	Gender Preference (M/F)	D.O.B	Age

Refund Information

There is a 15% processing fee for all refunds. No refunds after first week of class/program. No credits for missed classes.

PARENT CONSENT FORM

I, THE UDERSIGNED, GIVE PERMISSION FOR MY CHILD, WHOSE NAME APPEARS ABOVE, TO PARTICIPATE IN THE CRESTWOOD RECREATION CENTER PROGRAM. I UNDERSTAND THE NATURE OF THE ACTIVIES AND THE MINOR'S EXPERIENCE AND CAPABILITIES AND BELIEVE THE MINOR TO BE QUALIFIED, IN GOOD HEALTH, AND IN PROPER PHYSICAL CONDIDITON TO PARTICIPATE IN SUCH ACTIVITY. I AGREE TO RELIEVE THE CITY OF LOS ANGELES OF DEPARTMENT OF RECREATION AND PARKS, ITS OFFICERS, AGENTS AND EMPLOYEES FROM ANY LIABILITY IN CONNECTION WITH ANY INJURY TO MY CHILD IN CONNECTION WITH THIS PROGRAM. I UNDERSTAND **THE RECREATION FACILITY CARRIES NO INSURANCE.** I, THE UNDERSIGNED _____, A MINOR , DO HEREBY AUTHORIZE CRESTWOOD RECREATION CENTER AS AGENTS OF THE UNDERSIGNED TO CONSENT TO X-RAY EXAMINIATION, ANESTHETIC, MEDICAL OR SURGICAL DIAGNOSIS, OR TREATMENT AND HOSPITAL CARE WHICH IS DEEMED ADVISABLE BY, AND IS RENDERED UNDER THE GENERAL OR SPECIALIZED SUPERVISION OF ANY P[HYSICIAN LICENSED UNDER THE PROVISIONS OF THE MEDICAL PRACTICE ACT ON THE STAFF OF A LICENSED HOSPITAL, WHETHER SUCH DIAGNOSIS OR TREATMENT IS RENDERED AT THE OFFICE OF SAID PHYSICIAN OR A SAID HOSPITAL. IT IS UNDERSTOOD THAT THIS AUTHORIZATION IS GIVEN IN ADVANCE OF ANY SUCH DIAGNOSIS, TREATMENT OR HOSPITAL CARE WHICH THE AFORMENTIONED PHYSICIAN IN THE EXERCISE OF HIS BEST JUDGMENT MAY DEEM ADVISABLE. THIS AUTHORIZATION SHALL REMAIN EFFECTIVE FOR THE DURATION OF THE PROGRAM, UNLESS REVOKED SOONER IN WRITING AND DELIVERED TO THE SAID AGENT. **I have read and understand the Registration Information, Consent Form and the Refund Policy, I agree to the above terms.**

Signature:_____ **Date:**_____