

**Goose Creek Recreation Commission**  
**Post Office Box 39, Goose Creek, South Carolina 29445**  
**Community Center, 519-A N. Goose Creek Blvd., Phone (843) 569-4241 Fax (843) 569-4241**  
**Casey Center, 101 Old Moncks Corner Rd., Phone (843) 572-1321 Fax (843) 572-1242**

**PLEASE PRINT**

Name of Participant: \_\_\_\_\_

Address: \_\_\_\_\_ Gender M / F

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Subdivision: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_ Medical Ins. Co. Name: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Do you want to purchase playground Insurance: Yes: \_\_\_ No: \_\_\_

Do you live in the GCRC boundaries? \_\_\_ Any special needs to be aware of? Yes \_\_\_ No \_\_\_

If yes, please describe: \_\_\_\_\_

Waiver for Participation: I understand that there are always risks involved in participation in recreational activities. I acknowledge these risks and declare the participant physically able to participate in the activity. In the event of a medical emergency, I authorize the Goose Creek Recreation Commission or its representatives to obtain emergency medical treatment for my child (if parent is not available). In consideration of your accepting this registration, I hereby for myself, my child, my heirs, my executors and administrator, waive and release any and all rights and claims for damages I may have against the Goose Creek Recreation Commission or its groups. I likewise release from responsibility, any person transporting myself or my child to and from these activities. I further grant GCRC the unencumbered right to make promotional use of any pictures and/or video tapes taken of the registrant while participating in this program. Disclosure of your social security number is voluntary. These numbers are only used for medical information in the event of an emergency or for debt collection.

Signature: \_\_\_\_\_ Name (Print): \_\_\_\_\_  
(Parent/Legal Guardian if Participant is under 18)

Refunds must be requested prior to the second class meeting unless specified differently in the specific program policies.

There is a \$5 handling fee on all refunds. Approval Initial \_\_\_\_\_

**STAFF USE ONLY:** Program: \_\_\_\_\_ Date: \_\_\_\_\_

Residency Verified: \_\_\_\_\_ Staff Initial: \_\_\_\_\_