

LEOMINSTER RECREATION DEPARTMENT
Intermediate Program 2009 Ages 10 – 12

Monday, July 6th – Friday, August 14
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Registrations are done on a first-come first served basis or lottery with priority given to Leominster residents. The Leominster Recreation Department reserves the right to cap the number of registrations for any program based on availability of personnel, facilities or any other factors affecting the program.

Registrations and payments may be mailed to 25 West Street, Leominster, MA 01453 or dropped off at The Leominster Recreation Department, 40 Barrett Parkway, Leominster, MA for all programs. Make checks payable to the Leominster Recreation Department. Office #978-534-7529
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Participant First Name: _____ Last Name: _____

DOB: _____ AGE: _____ GRADE: _____ Sex: Male _____ Female _____

Address: _____ Home Phone: _____

City/State: _____ Zip: _____ E-mail: _____

The Teen Adventures Program is rain or shine. Teens will have an opportunity to play sports, games, arts and crafts, explore nature, and go on field trips including visits to the State Pool. The Programs will run for 6 weeks, 1 – week sessions, beginning July 6th and ending August 14, 2009. Hours are 9:00 – 3:00 p.m. There will be extended day offered in the mornings & afternoons for an additional cost. The cost is \$5.00 per session from 7:30 a.m. – 9:00 a.m. and/or 3:00 p.m. – 5:30 p.m. If you wish to sign your child up for extended day please fill out the extended day section. Non-Resident Fee: Add \$5.00 per program per week.

EMERGENCY CONTACT INFORMATION

*When emergency situations arise, we want to be able to handle them according to your wishes, if possible. Please fill in ALL the following information. Indicate by number () the order of preference for contacting the people listed.
 Mother's Name: _____ () Mother's Phone #: _____
 () Mother's Work #: _____ () Mother's Cell #: _____

Father's Name: _____ () Father's Phone #: _____
 () Father's Work #: _____ () Father's Cell #: _____

Emergency Contact: _____ () Emergency Phone: _____
 Doctor's Name: _____ () Doctor's Phone: _____

The Leominster Recreation Commission reserves the right to suspend any child from the program if there are behavioral problems that cannot be resolved.

GENERAL HEALTH: _____ ALLERGIES: _____
 ANY SPECIAL MEDICAL CARE? _____
 ACTIVITY RESTRICTIONS: _____

MY CHILD CAN BE PICKED UP **ONLY** BY (other than parent)
 1. _____ 2. _____

THIS FORM MAY BE DUPLICATED.

PHOTOGRAPHIC CONSENT AND WAIVER

- ___ My child _____ has permission to be photographed during Recreation programs for publicity purposes by members of the press.
- ___ My child _____ has permission to be photographed by Leominster Recreation staff only, and NOT by the press for publicity purposes.
- ___ My child _____ may NOT be photographed at any time.

I agree not to hold responsible the Leominster Recreation Commission; the City Of Leominster; the owners of the premises where the programs are held; or any of the parties connected with the program for any injury or accident that may occur during the program. I understand that if my child becomes a discipline problem, he/she will be dismissed from the program. No money will be refunded. I also grant permission for the Recreation Staff to seek medical care in the event I cannot be reached (All participants in any city recreation program must sign this waiver.)

Sign Here: Parent/Guardian: _____ Date: _____

PLEASE FILL OUT PROGRAM INFORMATION ON BACK----->

First Name: _____ Last Name: _____

INTERMEDIATE

The deadline for weekly registrations with payments must be made on the Thursday prior to the following week. After the initial registration, further weekly payments can be made at program office if space allows. Office # 978-534-7529

INTERMEDIATE PROGRAM: Ages 10-12. Location: Barrett Park

REGISTRATION FEE: \$65.00 per wk/ per child Extended Day Fee: \$5 a piece for each morning & afternoon session. ADDITIONAL CHILD \$5:00 OFF PER WEEK! NO DAILY FEE!

Week 1 July 6 – July 10	Week 2 July 13 – 17	Week 3 July 20 – 24	Week 4 July 27 – 31	Week 5 Aug. 3 – Aug. 7	Week 6 Aug. 10 – 14
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WEEK 1: Will your child attend Week 1? YES: _____ NO: _____

Please check extended day if needed:

Extended Mon. – AM (\$5): _____ PM (\$5): _____

Day: Tues. – AM (\$5): _____ PM (\$5): _____

Wed. – AM (\$5): _____ PM (\$5): _____

Thurs. – AM (\$5): _____ PM (\$5): _____

Fri. – AM (\$5): _____ PM (\$5): _____

Total extended days: _____ X \$5.00/ea. = Total: _____

Office use only: July 6 – 10

WEEK 1: Cost for the Week: \$65.00

Extended Day Amt Paid: _____

Total Amount Paid: _____

Date: _____ Check # _____

Cash: _____ Receipt # _____

WEEK 2: Will your child attend Week 2? YES: _____ NO: _____

Please check extended day if needed:

Extended Mon. – AM (\$5): _____ PM (\$5): _____

Day: Tues. – AM (\$5): _____ PM (\$5): _____

Wed. – AM (\$5): _____ PM (\$5): _____

Thurs. – AM (\$5): _____ PM (\$5): _____

Fri. – AM (\$5): _____ PM (\$5): _____

Total extended days: _____ X \$5.00/ea. = Total: _____

Office use only: July 13 – 17

WEEK 2: Cost for the Week: \$65.00

Extended Day Amt Paid: _____

Total Amount Paid: _____

Date: _____ Check # _____

Cash: _____ Receipt # _____

WEEK 3: Will your child attend Week 3? YES: _____ NO: _____

Please check extended day if needed:

Extended Mon. – AM (\$5): _____ PM (\$5): _____

Day: Tues. – AM (\$5): _____ PM (\$5): _____

Wed. – AM (\$5): _____ PM (\$5): _____

Thurs. – AM (\$5): _____ PM (\$5): _____

Fri. – AM (\$5): _____ PM (\$5): _____

Total extended days: _____ X \$5.00/ea. = Total: _____

Office use only: July 20 – 24

WEEK 3: Cost for the Week: \$65.00

Extended Day Amt Paid: _____

Total Amount Paid: _____

Date: _____ Check # _____

Cash: _____ Receipt # _____

WEEK 4: Will your child attend Week 4? YES: _____ NO: _____

Please check extended day if needed:

Extended Mon. – AM (\$5): _____ PM (\$5): _____

Day: Tues. – AM (\$5): _____ PM (\$5): _____

Wed. – AM (\$5): _____ PM (\$5): _____

Thurs. – AM (\$5): _____ PM (\$5): _____

Fri. – AM (\$5): _____ PM (\$5): _____

Total extended days: _____ X \$5.00/ea. = Total: _____

Office use only: July 27 – 31

WEEK 4: Cost for the Week: \$65.00

Extended Day Amt Paid: _____

Total Amount Paid: _____

Date: _____ Check # _____

Cash: _____ Receipt # _____

WEEK 5: Will your child attend Week 5? YES: _____ NO: _____

Please check extended day if needed:

Extended Mon. – AM (\$5): _____ PM (\$5): _____

Day: Tues. – AM (\$5): _____ PM (\$5): _____

Wed. – AM (\$5): _____ PM (\$5): _____

Thurs. – AM (\$5): _____ PM (\$5): _____

Fri. – AM (\$5): _____ PM (\$5): _____

Total extended days: _____ X \$5.00/ea. = Total: _____

Office use only: August 3 – 7

WEEK 5: Cost for the Week: \$65.00

Extended Day Amt Paid: _____

Total Amount Paid: _____

Date: _____ Check # _____

Cash: _____ Receipt # _____

WEEK 6: Will your child attend Week 6? YES: _____ NO: _____

Please check extended day if needed:

Extended Mon. – AM (\$5): _____ PM (\$5): _____

Day: Tues. – AM (\$5): _____ PM (\$5): _____

Wed. – AM (\$5): _____ PM (\$5): _____

Thurs. – AM (\$5): _____ PM (\$5): _____

Fri. – AM (\$5): _____ PM (\$5): _____

Total extended days: _____ X \$5.00/ea. = Total: _____

Office use only: August 10 – 14

WEEK 6: Cost for the Week: \$65.00

Extended Day Amt Paid: _____

Total Amount Paid: _____

Date: _____ Check # _____

Cash: _____ Receipt # _____