



# NEW CUSTOMER ACCOUNT ENROLLMENT FORM

For Office Use Only:

Date Received: \_\_\_\_\_ Received By: \_\_\_\_\_

## Section I - Customer Information

Customer Name: \_\_\_\_\_ City Resident?  Yes  No

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Customer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

What disabilities or conditions do you have which might limit participation? \_\_\_\_\_

What medications, if any, do you take at this time? \_\_\_\_\_

What allergies, if any, do you have at this time? \_\_\_\_\_

Please list names, relationships, and birth dates of all individuals you wish to be included on your account

- Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Disabilities? \_\_\_\_\_ Medications: \_\_\_\_\_ Allergies? \_\_\_\_\_

- Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Disabilities? \_\_\_\_\_ Medications: \_\_\_\_\_ Allergies? \_\_\_\_\_

- Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Disabilities? \_\_\_\_\_ Medications: \_\_\_\_\_ Allergies? \_\_\_\_\_

- Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Disabilities? \_\_\_\_\_ Medications: \_\_\_\_\_ Allergies? \_\_\_\_\_

- Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Disabilities? \_\_\_\_\_ Medications: \_\_\_\_\_ Allergies? \_\_\_\_\_

## Section II - Indemnification and Authorized Signatures

In consideration of myself or my minor child or ward being permitted to enroll and participate in this program, I agree to: 1. Assume all risks of this activity and understand that such activity is subject to mishap and even injury, and that participation in the activity could result in broken limbs, paralysis, or other serious injury or death; 2. Attend program pre-meeting(s), when offered, to learn specific program safety procedures; 3. Grant permission to transport me or my minor child or ward to and from the activity if required, and to hold harmless those who provide transportation; 4. Allow transportation of me or my minor child or ward to the nearest physician for medical treatment and agree to allow for immediate medical treatment when deemed necessary; 5. Wear proper clothing and protective equipment during the program and act in a safe and responsible manner so as not to endanger other persons or property; 6. Indemnify and hold harmless the City of Roanoke, its officers, officials, agents, instructors, employees, and volunteers from any and all claims, damages, losses, and expenses, including attorneys' fees, for any harm, injury, damage or loss which may be sustained by me or my minor child or ward, arising out of, or resulting from, participating in this activity; 7. Assign to the City of Roanoke, its nominees and agents, permission to use, publish and republish for purposes of advertising and trade, such use as the City may determine, information and reproductions of my likeness (photographic or otherwise) or that of my minor child or ward, with or without identification of me, or my minor child or ward by name; and 8. Allow my minor child or ward named above to participate in the program.

Print Applicant Name: \_\_\_\_\_

Customer Signature: \_\_\_\_\_ Date: \_\_\_\_\_