



Make Check(s) or Money Orders Payable To: **"BMPRD"**

ADMINISTRATION & RECREATION SERVICES OFFICE
 200 NW Pacific Park Lane, Bend, OR 97701
 (541) 389-7275 • Fax (541) 388-5429 • www.bendparksandrec.org

PLEASE PRINT & FILL OUT COMPLETELY

PLEASE CHECK IF NEW ADDRESS OR PHONE NUMBER

ACTIVITY NUMBER	ACTIVITY NAME	CUSTOMER/PARTICIPANT NAME			MI	DATE OF BIRTH	AGE	SEX	ACTIVITY FEE
		LAST	FIRST						
PARTICIPANT INFO									
			DATE:	TIME:		LOCATION:			
			DATE:	TIME:		LOCATION:			
			DATE:	TIME:		LOCATION:			



Check here if you want an assessment team to contact you about disability accommodations.

PAYMENT

LAST _____ FIRST _____ MI _____ DATE _____
 ADDRESS _____ ADULT DATE OF BIRTH _____
 NW NE SW SE Other E-Mail Address: _____
 CITY _____ STATE _____ ZIP CODE _____ In-District Out-of-District
 HOME PHONE () _____ WORK PHONE () _____ EMERGENCY () _____

INFORMED CONSENT/PARTICIPANT RELEASE

"I, the participant or the parent/guardian of the above named participant understand the possibility of injuries resulting from the activities indicated above or other activities sponsored by the Bend Metro Park and Recreation District ("District"). I hereby acknowledge and accept all risks and hazards incidental to participation in such activities. I hereby release, absolve, indemnify and hold harmless the District and its directors, employees and agents from any injury, whether to person or property, of the participant resulting from such activities. In case of personal injury to participant, I hereby waive any and all claims against the District, its directors, employees and agents. I understand there is no insurance coverage provided by District for participant and that such coverage constitutes a responsibility of the participant and/or the undersigned. I hereby release from liability and waive any and all claims against any person who, on behalf of District, is involved in the transportation of participant in connection with District activities. I hereby consent to emergency medical treatment of participant to assure prompt treatment and prevention of undue delay, and I understand that such treatment may be provided by either a licensed physician or trained emergency care technician. I agree that the District may use, reproduce, disclose and distribute participant's name and/or likeness for District marketing purposes. I acknowledge that I have read, fully understand and accept the above provisions and I recognize that the District is relying on such acceptance in permitting participant to engage in District activities."

SCHOLARSHIP DONATION: _____

TOTAL FEES

- CASH MONEY ORDER
- CHECK # _____
- CREDIT CARD/DEBIT (VISA & Mastercard Only)

- EXP. DATE _____
- SCHOLARSHIP
- OTHER

RECEIVED BY: _____

Participant or Parent/Guardian Signature _____ Date _____