Middlesex Recreation Department, 1200 Mountain Ave., Middlesex, NJ 08846 (732) 356-7966.
Please fill out one form per child if registering multiple children. Make checks payable to Middlesex Recreation Dept.

TODDLER PROGRAM

$40.00 REGISTRATION FEE PER SESSION (10 wks)
(OUT-OF-TOWNERS $65.00)
Please check session you are registering for:
_____Fall _____Winter _____Spring

DO NOT WRITE IN BOX – for office use only

Reg. Fee Pd: _____F _____W _____S

Receipt #_____

Date Rcv'd_____

The Fall session begins the "year" of Toddler Playgroup. Registration begins on July 3, 2008. This session will be first come first serve. The participants of the Fall session will have one week to register for the next session before the class is open to the public. In order to register, this form must be completed and payment must be made. NO SPOTS WILL BE HELD. Siblings/or other children who do not meet the eligibility requirements and thus NOT REGISTERED are not allowed to attend with the exception of an infant in a seat. Proof of residency may be required. No refunds will be issued after: fall session - Sept. 19, 2008, winter session - Dec. 12, 2008 and spring session - March 27, 2009. Classes must have a MINIMUM of 12 registered children. If the minimum is not reached the children will be placed into the 2nd or 3rd choice depending on enrollment of the classes.

CHILD'S NAME _____ BOY _____ GIRL _____

ADDRESS _____ TOWN _____ ZIP_____

PHONE _____ PRESENT AGE _____ BIRTH DATE _____/_____/_____

PLEASE INDICATE YOUR 1ST, 2ND, AND 3RD CHOICE OF CLASSES:
MONDAY- 9:00-10:00 _____ (AGE 1-2) TUESDAY- 9:00-10:00 _____ (AGE 3-4)
MONDAY- 10:15-11:15 _____ (AGE 3-4) TUESDAY- 10:15-11:15 _____ (AGE 1-2)
MONDAY- 11:30-12:30 _____ (COMBINATION)

EMERGENCY TREATMENT RELEASE

As a parent and/or guardian of _____, a minor, I herewith authorize the treatment by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. Dates during which release is granted: **September 2008 through June 2009.**

Parent (s)/Guardian Info:

_____ _____Ph # _____ Cell #_____
Mothers Name address (if different than above)

_____ _____Ph # _____Cell# _____
Fathers Name address (if different than above)

Mothers email:_____ Fathers email:_____

Other contact in case of emergency (DO NOT LIST YOURSELF):

Name _____Phone_____ H / W / C Relationship to child_____

Specific medical allergies, chronic illness or other medical conditions the staff should be aware of:_____

_____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence. I confirm that my child is up to date on all immunizations as required by the NJ Dept. of Health and Senior Services Annual Immunizations Report. I also agree that all the information provided is correct and factual. If information is found to be false, I understand that my child will be expelled from program without reimbursement of fees paid.

Parent Signature _____ Date: _____/_____/_____