DCSC Membership
2019 Participation Agreement
City of Dublin
5600 Post Road
Dublin OH 43017-1212

PLEASE PRINT

Class #559100.01

Name: ____

Address: ____

____

Date of Birth: ______/______/________

Telephone: Home (   ) ______________ Work (   ) ______________ Cell (   ) ______________

Email Address: _______________________________________

PLEASE LIST:

Allergies to Medications: _________________________________

Prescription Medicines: __________________________________

EMERGENCY CONTACT INFORMATION:

Name: ____

Telephone: Home (   ) ______________ Work (   ) ______________ Cell (   ) ______________

PHYSICIAN INFORMATION:

Name: ____

I agree to provide and carry my own medications at all activities. I agree to inform the program leaders of my special health considerations.

I agree to follow the instructions given by the program leaders and any rules and regulations of the City of Dublin, Recreation Services.

In consideration of the opportunity afforded me to participate in the DCSC organization, I waive any rights or causes of actions against the City of Dublin, Ohio, its elected and appointed officials and employees, and DCSC, Inc., its elected and appointed officials and volunteers, for any injury to me or damage to my property sustained in connection with DCSC program activities.

______________________ ______________________________________

Date Signature

Seniors/SNRMEDAGRFrontDesk2019

DCRC Front Desk please return this form to Stacie Neilan.