3. Black or African American Race: Please indicate above using corresponding number: (Optional) American Indian or Alaskan Native Payment (check all that apply) ____ Cash ___ Check #_ Payment Amount \$_ Name as printed on card Credit Card Number: Participant's Full Name **Emergency Contact Name** Primary Phone Email (Required for registration confirmation OR send a stamped, self-addressed envelope) "1 agree to receive MSCR promotional email Street Address (Head of Household) Last Name Madison School & Community Recreation Office: MSCR Central, 328 E Lakeside St, Madison, WI 53715 Phone: 608-204-3000 MSCR Registration Form lam requesting a Payment Plan (camps Only) Authorized Signature: Cell Phone Other Pacific Islander 5. Hispanic Native Hawaiian or Gender *See page 55. Date of Birth mm/dd/yy (Payable to MSCR) Grade 2024-2025 7. Multiracial Expiration Date: Three Digit Code . Credit Card: MasterCard or Visa Only Race (see below) **Emergency Contact Phone** ___Yes ___ No, Non MI See the Policy Page. Are you an MMSD resident? (Check one) City First Name No, Non MMSD residents pay 50% more. Alternate, if any Alternate, if any Alternate, if any St ß if any 1st 1st Alternate, Choice State **Program Title** WPCRC Photo ID required for programs at Warner Park Community Recreation Center. Go to mscr.org for more information. By registering or participating, the registrant understands that individual accident insurance is not provided for MSCR programs and agrees to adhere to program rules. I do hereby, for myself, my heirs, executors, and administrators, waive, release, and forever discharge any and all rights and adams for damages that In may have or that may hereafter accrue to me arising out of or, in any way connected with my participation in MSCR Program. Photos or videos may be taken during program for educational and marketing purposes. I have read and agree to follow the registration and refund policies. X Signature: lacknowledge receipt of Concussion & Sudden Cardiac Arrest Information page 56 Youth Sports Participants: Zip Birth Date (mm/dd/yy) Liability Waiver - Signature Required for Participation Location Does the participant require an accommodation or special assistance due to a disability? If so, please explain. Do you have any medical conditions or concerns of which our staff need to be aware? (Asthma, Allergies, etc.) Fax: 608-204-0557 Email: mscr@madison.k12.wi.us Start Date Start Time Course # Total Donation \$_ Fee Total \$ Fee *Fee Assis-tance Request *Must complete form on back.