

**ADULT FORM 2026 – 2027**  
**TOWN OF GRANBY RECREATION DEPARTMENT**  
**PROGRAM LIABILITY / EMERGENCY PROCEDURE**



Name of Participant \_\_\_\_\_ Birthdate \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Physical Address \_\_\_\_\_ E-mail: \_\_\_\_\_  
Home / Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
In case of emergency, please contact:  
Name \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
Hospital / Clinic Preference \_\_\_\_\_  
Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Allergies \_\_\_\_\_  
Medical conditions we should be aware of \_\_\_\_\_  
\_\_\_\_\_

I, the undersigned, am the participant in a Granby Recreation Department program.

I/we, hereby request that the Town of Granby Recreation Department (hereafter GRD) accept the application of myself for enrollment in any GRD sponsored programs. In submitting and signing this application, I represent that I am aware of the risks and potential dangers involved in connection with the transportation and participation in attending any recreation programs, and that I know that risks and dangers may arise, absent gross negligence, driving to and from, as well as during any recreation program.

Now, therefore, in consideration of the acceptance of the participant in the GRD programs, I for myself and all other members of my family, hereby release and discharge the Granby Recreation Department, the Town of Granby, their Boards of Directors, employees, agents, and volunteers from any and all claims, demands, and causes of action of any sort, including negligence, totally or partially causing injuries sustained to the person or property of the participant resulting in connection with participation, directly or indirectly, in the GRD programs for any reason or fault.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

**AUTHORIZATION FOR EMERGENCY MEDICAL CARE:** I hereby understand that basic first aid may be given for minor injuries to myself. I hereby give my consent to the administration of any treatment deemed necessary by my physician listed above, or in the event he / she is not available, by another licensed physician, and transfer myself to the hospital listed above or any hospital or clinic reasonably accessible. This consent does not cover major surgery unless the medical opinions of two licensed physicians concur in the necessity for such surgery. I agree to pay for all expenses incurred including reasonable attorney's fees if I fail to make such payment.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_