Town of Schroeppel
Department of Community Services
69 Co. Rt. 57A, Phoenix, New York 13135
695-2801 FAX 695-3231
hknipp@townofschroeppel.com

Office Use Only:
Date Paid: _____
Amount Paid: _____
Cash _____ Check# _____
Online Registration _____
Res _____ Non Res _____
Late Fee _____
Additional Notes _____
_____
_____

2026 YOUTH TRACK & FIELD REGISTRATION

SIGN UP FOR 1 OR FOR BOTH!!!

REGISTER by: June 19th, 2026 Ages 5-13

SESSION 1*: TRACK & FIELD** ***June 30th – August 14th
Tuesdays 6:30-8:00 pm & Saturdays, 10-11:30 am

SESSION 2*: CROSS COUNTRY** ***August 11th – August 29th
Tuesdays 6:00-7:30 pm & Saturdays, 9-10:30 am

Please come with sunscreen and bug spray if needed.

Location: First night, please meet at William J Farley Community Park

PLEASE PRINT **DATE OF BIRTH_____**

PLAYER'S NAME_____ AGE AS OF June 30th_____
LAST FIRST
ADDRESS_____
GRADE_____ *Male*_____ *Female*_____
CITY _____ZIP_____
PHONE#_____CELL# _____EMAIL_____
Is the participant a town resident? _____

List any medical conditions or other conditions: _____

A written doctor's release is required if you have asthma or health problems. Are there any physical or health conditions that we need to be aware of? Specify: _____

Parent / Guardian Information: ***(Please list in contact order)***

Name: _____ Relation: _____

Phone Number: _____ Email: _____

Name: _____ Relation: _____

Phone Number: _____ Email: _____

(over)

Emergency Contact:

Name: _____ **Relation:** _____

Phone Number: _____

Doctor to notify in case of emergency: _____ **Phone:** _____

Hospital preference, if any: _____

*****CONSENT FOR MEDICAL TREATMENT OF A MINOR*****

I understand that there is no accident or injury insurance coverage for injuries incurred in this program.
I agree to be financially responsible for any injuries related to program participation.
I understand that the fees for this program are not refundable except in the case of departmental cancellation.
If the participant named above is a minor:

1) **My signature signifies my permission for this person to participate in this program.**
2) **I give my consent for a licensed physician to perform whatever medical treatment is deemed necessary in my absence.**
3) **I give permission for the above names participant to be transported to the nearest available medical facility in the event of an injury.**

_____ _____

Signature of Parent or Guardian OR Adult Participant **Date**

I give my permission for my child to be photographed for publicity purposes.

Signed: _____ **Date:** _____

Registrations are limited.

Parental/Adult Support

_____ Yes, I will help.
_____ Name
If we do not get enough volunteers, we will be unable to run the program. Please consider helping.