Gates Recreation & Parks Department
2021 Golf League Registration Form

First Name:_____ Last Name:_____ D.O.B.:_____

Address:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

E-Mail: _____

_____ **Information and updates will be emailed unless you indicate here to mail only.**

Please Check One:

□ Class # 15210A
9 Hole – Tee Off between 8:00 - 10:00 AM

□ Class # 15210B
18 Hole – Tee Off between 7:00 – 8:30 AM

□ I am golfing with: OR □ Please place me with other golfers

1. _____

2. _____

3. _____

Please indicate level of play:

□ Beginner □ Intermediate

□ Advanced (Par or better)

Please list any known dates you will not be attending:

Please read the following statement:

I assume all risks and hazards incidental to the conduct of the activity and do hereby further release and hold harmless the Town of Gates and the Town of Gates Recreation and Parks Department staff and volunteers. I give permission to a licensed physician or hospital staff to administer emergency medical care deemed necessary for myself when normal permission is unavailable. I certify that I am in good physical health and have no limitations other than those I have listed above which may predispose me to risk during this program. I also fully realize that I must provide proper hospitalization. The Town of Gates does not provide accident insurance coverage. I have read and understand the departments refund policy and procedure.

Participant signature:_____ Date_____

League fee is $20. Make check payable to: Gates Recreation & Parks Department and return to:

Gates Recreation & Parks Department
1605 Buffalo Road, Rochester, NY 14624

Registration Deadline is April 26

*Schedules and Tee Times will be e-mailed out by April 28.

GATES RECREATION & PARKS DEPARTMENT
ADULT GOLF LEAGUE

MEDICAL AUTHORIZATION/EMERGENCY INFORMATION

Last Name _____ First Name _____ M.I._____

Date of Birth (mm/dd/yr) _____ Age _____ Male_____ Female_____

Address_____ Zip _____Phone _____

Emergency Contact _____ Phone number _____

Relationship _____

Emer. Contact #2 _____ Phone number _____

Relationship _____

Medical Insurance Plan _____ Number _____

Doctor _____ Phone Number _____

Disabilities _____

Allergies _____

Medications _____

Other notes _____

To the best of my knowledge, the information contained on this form is true. I give my permission for this information to be released in the event of an emergency to a EMT, licensed physician or other hospital staff member to carry out emergency medical care deemed necessary when normal permission is unavailable.

SIGNATURE REQUIRED _____ Date _____