

**BOARD OF RECREATION COMMISSIONERS  
84 BROAD STREET – BLOOMFIELD, NJ 07003  
973-743-9074**

**2025-2026 SPECIAL NEEDS**

Please check which program you are interested in:

**HORIZONS** \_\_\_ **Friday Night** \_\_\_ (Calendar will be distributed monthly)  
**Registration Fee: \$50.00**

**NAME:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

\_\_\_\_\_ **CELL/BEEPER:** \_\_\_\_\_

**EMAIL:** \_\_\_\_\_

**MALE** \_\_\_ **FEMALE** \_\_\_ **ETHNICITY** (optional) \_\_\_\_\_ **BIRTH DATE** \_\_\_\_\_

He/She has our permission to engage in this activity and we hereby release the Board of Recreation Commissioners of the Township of Bloomfield its officers, agents, servants, and employee; The Board of Education of the Township Bloomfield, its officers, agents, servants and employees; The Township of Bloomfield, its officers, agents, servants and employees from any and all liability with responsibility to any injuries that may be sustained by our child while going to, while engaged in and returning from this activity.

**PERMISSION TO PUBLISH:** In permitting the entrant to participate, I am specifically granting permission for you to use the name, likeness, voice and words of the entrant in television, radio, films, newspaper, magazines and other media, and in any form not heretofore described, for the purpose of advertising or communicating the purpose and support such activities. I, the undersigned, have read and fully understand the provisions of the above release and have explained them, if applicable, to said entrant. I hereby agree that I and said entrant will be bound thereby.

**EMERGENCY MEDICAL AUTHORIZATION**

In the event that I am unable to be reached by telephone, I do authorize:

**NAME:** \_\_\_\_\_ **PHONE NO.** \_\_\_\_\_

To act on my behalf, or if neither can be reached, do hereby grant permission to a licensed physician or hospital to perform diagnosis, treatment, and surgery on the aforesaid minor for any emergency illness or injury, as deemed necessary by such competent medical opinion.

Are there any special health problems or characteristics of which your child's director/counselor should be made aware of: \_\_\_\_\_

\_\_\_\_\_

**Child's Classification:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

CASH \_\_\_\_\_ CHECK \_\_\_\_\_ RECEIPT NO. \_\_\_\_\_ DATE \_\_\_\_\_ BY \_\_\_\_\_