



# MONDAY, OCTOBER 8TH NOON-5PM

Barrington's Day of Caring is a community wide event to bring together our community to help those in need through service projects

## 'DAY OF CARING' REGISTRATION FORM

Participant Name: \_\_\_\_\_

Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

T-Shirt Size (Circle): Youth M L Adult S M L XL XXL

Home Address: \_\_\_\_\_

Parents/Guardians Names: \_\_\_\_\_

Home Ph: \_\_\_\_\_

Cell Ph: \_\_\_\_\_

Participant Email: \_\_\_\_\_ @ \_\_\_\_\_

Parent/Guardian Email: \_\_\_\_\_ @ \_\_\_\_\_

### Skills Information:

What is your usual occupation: \_\_\_\_\_

I am \_\_\_ I am not \_\_\_ comfortable entering/working inside a private residence.

Please indicate on this form your approximate level of skill using 1-4 to grade experience as:

- 1- Can supervise or teach this activity
- 2- Able to competently perform this activity
- 3- Could perform this activity with sufficient instruction
- 4- Have never done this, or not a skill of mine

Carpentry	Cement Work	Demolition	Drywall	Electrical	Floor/Tile	Glasswork	Masonry	Painting	Plumbing	Roofing	Yardwork



**MONDAY, OCTOBER 8TH  
NOON-5PM**

**UNDER 16 MUST BE  
ACCOMPANIED BY  
AN ADULT**

**‘DAY OF CARING’ REGISTRATION FORM**

**How to Register: Mail or drop off to:**

**Barrington Town Hall– Town Clerk’s Office**

**283 County Road, Barrington, RI 02806**

I, \_\_\_\_\_, hereby give my approval for my participation in any/all activities during the Barrington Day of Caring 2018 program. I assume all risks and hazards incidental to such participation, including transportation to and from such activities, and hereby waive, release, absolve, indemnify, and agree to hold harmless all individuals responsible for the conduct or activity involving this program. 2. MEDICAL CONDITIONS: I understand that myself or my children requiring special attention are reviewed on a case-by-case basis with the program director (s). I understand that this program does not receive specialized training for various special needs, but will work with individuals as appropriate. I will provide as much detail as possible, including any physical/emotional needs or medications involved so the volunteers will be able to provide a positive experience. The program director (s) reserves the right to withdraw anyone from the program if we are unable to meet the special needs of the individual. Medical Conditions and/or Food Allergies: \_\_\_\_\_

3. RISK FACTORS: The undersigned understands and acknowledges that the use of equipment, facilities and services provided by the Town of Barrington involves risks such as, but not limited to, the following which might result from the use of equipment or facilities, from the activity itself, from the acts of others, or from the unavailability of emergency medical care - RISK OF PROPERTY DAMAGE, BODILY INJURY, AND POSSIBLE DEATH, and that he assumes all risks that arise from, but not limited to, those risk factors described above. 4. RELEASE: The undersigned releases the Town of Barrington, its employees and agents, and agrees not to sue them on account of or in conjunction with any claims, causes of action, injuries, damage, cost of expenses arising out of the activity, including those based on death, bodily injury or property damage whether or not caused by the acts, omissions or other fault of the parties being released. 5. EMERGENCY TREATMENT CONSENT: The undersigned, as a participant in the subject activity, hereby consents to medical treatment in a medical emergency where the undersigned is unable to consent to such treatment. 6. ACKNOWLEDGMENT: The undersigned has read and understands this agreement.

Check one: \_\_\_\_\_ Yes, I give permission to be photographed

\_\_\_\_\_ No, I do not give permission to be photographed

Signature of Participant: \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_