Kensington Park Pool Association

Membership Contract

Name_____ Spouse's name _____

Mailing Address _____

Email_____
(This is our primary source of communication)

Cell Phone: _____ Home/Work_____

Membership Options

Please circle one

Family- $400
(Two adults and all children, 21 and under living in household)

Couple- $275
(Any two people)

Grandparents-$275
(Two adults and all grandchildren 21 and under)

Grandparent Weekly $55/week

Single Parent- $310
(One adult and all children 21 and under living in household)

Single-$180
(any one adult 21-55)

Senior- $155
(any one adult over 55)

Active duty Military with a valid ID may receive 25% off any membership when paying with check or cash **ONLY**

Total number of people on your membership: Adults_____ Kids _____

Amount Paid_____ Date_____

Please Circle One Paypal (list paypal name) _____ Check#_____ Cash
(Full paypal fee will apply automatically on paypal)

Member Release (MUST initial each paragraph and sign below)

I certify that the family members listed are physically able and fit to participate in any and all activities of the Kensington Park Pool. I totally release and absolve the Kensington Park Association Inc. and any officers of the committee, Board of Directors, and lifeguards from any and all liability due to illness or injuries to any family member as a result of participation in pool activities. I accept full responsibility for all illness and injuries. I agree to pay medical expenses, hospital bills, and/or doctor bills. (Initial____)

I agree to follow the rules of the pool and to ensure that minors and guests under my care and invitation understand and follow the same rules. I also agree to compensate the pool for any damages caused by myself, minors and/or guests under my care and invitation. (Initial ____)

I have read the above and fully understand all implications. I have been issued _____ arm bands. I (we) understand that arm bands are required for admittance to the pool. If lost, a $10 fee per band will be charged. These arm bands are for MEMBERS listed on this membership ONLY. Anyone not listed on this membership contract must pay a $5 per day guest fee. Violation will result in forfeited membership without refunds. (Initial____)

I understand that Pool Hours are subject to change due to weather, lifeguard availability and unforeseen unavoidable circumstances. (Initial_____)

Member Signature:_____ Date:_____

Medical Release

I, the undersigned, do hereby authorize and consent, for anyone of my family listed below, to any X-ray, examination, anesthetic, medical or surgical diagnosis or procedure under the general or specific supervision of any member of the medical staff or of a dentist licensed under the provisions of the Public Health Law of the State Department of Georgia and on the staff of any hospital holding current operating certificate issued by the State Department of Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that the effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above mentioned treatments will not be withheld if the undersigned cannot be reached.

I, the undersigned, do hereby give my permission to the officers, managers, lifeguards or agent of the Kensington Park Pool to obtain and administer such medical aid and assistance as might be required for myself or my child if such assistance of any emergency nature becomes necessary.

In no event will the Kensington Park Pool, its officers, leaders, lifeguards or agents be held liable for any first aid rendered or treatment, drug and medicine, or surgical procedure performed pursuant to this consent.

Please include information about anyone who may be bringing your child to the pool on a regular basis. Also include any relevant information on ANY member of your family who may have the following health problems: heart disease, bee/insect or any other allergies, epilepsy, asthma, hemophilia, diabetes or hypoglocemia, bladder or bowel control issues, HIV/AIDS or any other illness/disability.

Full Member Name Age Physican/Hospital/Dentist

_____

_____

Children/Grandchildren

_____

_____

_____

_____

Health Insurance ID_____

Emergency Contact_____ Relationship _____

Phone _____

Signature of Member_____Date_____

Updated 03/2025