



Gaithersburg
A CHARACTER COUNTS! City

City of Gaithersburg

301-258-6350

www.gaithersburgmd.gov

MARC Train & DC

5 S Summit Ave, Gaithersburg, MD 20877 (meet at Olde Towne Youth Center)

Activity #45663

GYC & Student Union Members, grades 6-12

**Departs from/returns to the Olde Towne Youth Center
(301 Teachers Way)**

Friday, August 12, 2016

7:30am-3:30pm

The trip returns at 3:30pm, but the Youth Center will be open until 6pm if participants choose to stay.

\$20 - Fee includes an optional lunch.

Bring money if you want to purchase food or souvenirs.



Questions?

Call Maura Dinwiddie or Sara Morgan
301-258-6350 or 301-258-6440
mdinwiddie@gaitersburgmd.gov
smorgan@gaitersburgmd.gov

The City of Gaithersburg is committed to making reasonable accommodations as required by the Americans with Disabilities Act. Requests must be made at least three weeks prior to the start of the program. Call 301-258-6350 to indicate what accommodations are needed.

MARC Train & DC Sightseeing - GYC & Student Union - 8/12/16

Check here if new address/phone since last time registered.

Payer's Last Name _____ Payer's First Name _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ City Resident Nonresident

Email _____

Participant's Name	Sex M/F	Birthdate M/D/Y	Activity Name	Activity #	Location	Start Date	Grade	School	Fee
			MARC Train & DC	45663	OTYC	8/26/16			
			MARC Train & DC	45663	OTYC	8/26/16			

Total \$

I hereby grant permission for me/my child to attend the activity sponsored by the City of Gaithersburg. I understand that I am responsible for my/my child's insurance in case of injury. Furthermore, I understand that although safety precautions will be observed, the City of Gaithersburg, employees and agents will not be responsible for any personal property lost by me/my child or any injury sustained in the program. I also consent to the City's use of any photographs and/or video tapes made of the program.

_____ **Print Parent/Guardian Name**

_____ **Signature of Parent/Guardian**

Does your child have any allergies, medications or conditions that may affect participation in the program? **Y** **N**

Please specify:

Amount Paid \$ _____ Cash Check # _____

Visa/MC# _____ Exp. Date ___/___

Signature (name on card) _____

Print Name _____

Office Use Only: # 45663

Rec'd: _____ Initials _____

W P M F Resident: Y N

Pr: _____ Date: _____