TEAM CENTRAL GYMNASTIC ACADEMY

Cmptr	Different Last Name	Level	Fall/Wntr/Spr Class	Sum Class	Yearly Reg	R & P	Staff Initials

Student's Name _____ DOB ____ /_____ /_____ M F School _____

Home Phone # _____ Medical/Physical Concerns _____ How Did You Hear About Us _____

Parent/Guardian Information Car/Beeper Phone # _____ e-mail _____

Father's Name _____ Employer _____ Work Phone # _____

Mother's Name _____ Employer _____ Work Phone # _____

Home Address _____ City _____ State _____ Zip _____

Emergency Contact
(other than parent) _____ Relationship _____ Phone # _____

Doctor's Name _____ Phone # _____

PERMISSION FOR MEDICAL TREATMENT: I confirm that the above named person is in good health. I hereby authorize simple first aid and consent to any x-ray, exam and medical or surgical diagnosis which is deemed necessary.
RELEASE: I hereby consent to have myself and/or my child/ward participate in programs offered by Team Central Gymnastic Academy. It is hereby agreed that I, my child(ren) adopted or otherwise, my executors, waive and release all rights and claims for damages that I may have at any against Team Central Gymnastic Academy, its representatives whether paid or volunteer for any injury or damages in connection with the Gymnastics program or other activities related to Gymnastics. The risks involved in respect to such a program are fully understood, as I have read the Rules & Policies Safety Statement.
I HEREBY GIVE PERMISSION FOR MEDICAL TREATMENT AND AGREE WITH THE RELEASE AS STATED ABOVE:

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

---------- Office Use Only ----------

Start Date _____Trial _____ Check # _____ Dated _____ Amount _____ Payment For _____

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