River City Gymnastics Registration Form

Family

Mother: First _____ Last _____ MI __

Cell (____)_____ Home (____)_____ Work (____)_____

Father: First _____ Last _____ MI __

Cell (____)_____ Home (____)_____ Work (____)_____

Emergency Contact (Someone other than mother or father)

Name _____ Relationship to Student _____

Cell (____)_____ Home (____)_____ Work (____)_____

Billing Address

Street _____

City _____ State _____ Zip _____

Email Addresses

Mom _____ Dad _____

How did you hear about us? _____

Please Read and Initial

_____ Initial Here I hereby give RCG my permission to use my child's/children's name/picture for promotional/advertising purposes now or in the future.

_____ Initial Here Tuition is paid monthly and is due on the First Day of Each Month. A $10 late fee will be added if the tuition is not received by the 15th of the month. For any collection action or litigation concerning this Agreement, I agree to pay reasonable attorney's fees, court costs, interest, and collection costs for RCG.

_____ Initial Here An Official Drop Notice must be turned in by the 15th of the month to avoid next month's billing cycle. Forms are available from the front desk.

_____ Initial Here I acknowledge that I carry health insurance on my child/children as listed on the back of this page & I will notify the office if my insurance changes.

_____ Initial Here I understand that siblings and other minors are not allowed in the gym during class. I understand that siblings and other minors must wait in the lobby or observation area and must be accompanied by an adult the entire time.

Office Use Only

Anniversary Fee: 1st child _____ 2nd child _____ 3rd child _____ 4th child _____ = Total _____

Tuition: Month _____ Monthly Price _____ # of Classes left in the Month _____ = Total _____

= Total _____

Payment Date ____/____/_____ Check # _____ CC Authorization # _____ Cash (Date) _____

Student

First ______________________________ Last ________________________________ Gender ____ DOB ____/____/_______

Allergies or medical concerns: ____

Medical Insurance Provider ____ Phone _______________________________

Enrollment: Class _______________________ Day ___________________ Time ________________

Enrollment: Class _______________________ Day ___________________ Time ________________

Trial Date ____/____/______ Start Date ____/____/______

Student

First ______________________________ Last ________________________________ Gender ____ DOB ____/____/_______

Allergies or medical concerns: ____

Medical Insurance Provider ____ Phone _______________________________

Enrollment: Class _______________________ Day ___________________ Time ________________

Enrollment: Class _______________________ Day ___________________ Time ________________

Trial Date ____/____/______ Start Date ____/____/______

Student

First ______________________________ Last ________________________________ Gender ____ DOB ____/____/_______

Allergies or medical concerns: ____

Medical Insurance Provider ____ Phone _______________________________

Enrollment: Class _______________________ Day ___________________ Time ________________

Enrollment: Class _______________________ Day ___________________ Time ________________

Trial Date ____/____/______ Start Date ____/____/______

Student

First ______________________________ Last ________________________________ Gender ____ DOB ____/____/_______

Allergies or medical concerns: ____

Medical Insurance Provider ____ Phone _______________________________

Enrollment: Class _______________________ Day ___________________ Time ________________

Enrollment: Class _______________________ Day ___________________ Time ________________

Trial Date ____/____/______ Start Date ____/____/______