Spring Fling

Registration

**Childs Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_**

**Class and Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shirt Size (Youth S/M/L): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parents Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Address Street City State Zip**

I, the undersigned, understand that STARS Gymnastics requires all fees paid in full before being allowed to participate in any programs hosted at STARS Gymnastics. Further, I the undersigned waive STARS Gymnastics of all liability for any injuries, illnesses, or loss of property while at STARS Gymnastics. In the event that I/my child should require any minor medical or surgical treatment and/or medication during STARS Gymnastics programs. I authorize such physician or emergency care staff that STARS Gymnastics may appoint or designate to carry out the necessary treatment, or to take me/my child to the emergency room of the nearest hospital and I further authorize the hospital and its medical staff to provide the treatment deemed necessary by them for the well-being of myself/my child. It is understood, however that if hospitalization or treatment of a more serious nature is required, I will be contacted by telephone for permission.

Signature (parent/guardian) Date­­­­­­­: .

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