

## Atlanta Gymnastics Center 2008– 2009 Program Registration Form

Class: \_\_\_\_\_ Day: \_\_\_\_\_ Time: \_\_\_\_\_

Yearly Registration Fee (\$35.00): \_\_\_\_\_ Tuition (2 months): \_\_\_\_\_ Deposit (equal to 1 month): \_\_\_\_\_

### PARTICIPANT INFORMATION

Participant: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_  
(Last) (First) (MI)

Address: \_\_\_\_\_ Home Telephone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### PARENT/GUARDIAN INFORMATION

Mother's Name: _____	Work Telephone: _____
Place of Employment: _____	Cellular Phone/Beeper: _____
	E mail: _____
Father's Name: _____	Work Telephone: _____
Place of Employment: _____	Cellular Phone/Beeper: _____
	E mail: _____
Emergency Contact: _____	Relationship: _____
	Telephone Number: _____

### MEDICAL INFORMATION

Primary Care Physician: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_ After Hours Telephone: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Allergies: \_\_\_\_\_

List all previous injuries and/or physical limitation (s): \_\_\_\_\_

\_\_\_\_\_

List all current medications: \_\_\_\_\_

### AUTHORIZATION

**Authorization to Transport:** The following individuals have my authorization to transport my child from Atlanta Gymnastics Center. I understand and agree that these individuals are the only persons to whom my child will be released:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**Video and Photography Release:** I understand that my child's photograph/video may be taken during the course of class instruction or during a special event. I hereby grant \_\_\_/do not grant \_\_\_ my permission for the resulting video and/or photograph to be used for any and all publicity and printing purposes.

**Notice of Termination:** I understand Atlanta Gymnastics Center requires a written one (1) month termination of participation notice be submitted to the Gym Director. I further understand that if notice is not received, I will forfeit the one month's deposit required at registration.

I understand that in any activity the potential exists for injury, minimal to catastrophic. Atlanta Gymnastics Center, it's employees, agents, officers and directors shall not be responsible for losses and damages associated with participation in any activity, exhibition, competition, or clinic or travel to or from any event in which the above named is involved. Furthermore, I hereby release Atlanta Gymnastics Center staff to render first aid in the event of any injury or illness, to seek medical assistance if deemed necessary and to transport to a medical facility or to call an ambulance.

I have read and agree to the policies and procedures as set forth in the Atlanta Gymnastics Center team and class handbook.

Parental Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### METHOD OF PAYMENT

Check Number: \_\_\_\_\_ Cash: \_\_\_\_\_ Credit Card: \_\_\_\_\_ Credit Card Number: \_\_\_\_\_ Date of Expiration: \_\_\_\_\_

If payment is made by credit card, the following statement is to be authorized by the card holder's signature: "I authorize Atlanta Gymnastics to charge my credit card the amount of \$ \_\_\_\_\_ and do agree to pay all charges in accordance with my credit card agreement."

Card Holder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I agree future payments to be charged to my credit card: \_\_\_\_\_ Yes I decline future payments be charged to my credit card: \_\_\_\_\_ No

## Medical History Questionnaire

Participant: \_\_\_\_\_  
 (Last Name) (First Name) (Middle Initial)

Please Circle Either "YES" or "NO" to all questions and provide additional details where requested. You may put details attached to this form if needed. All information is strictly confidential.

- Does the participant have any allergies to medication (aspirin, penicillin, sulfa, etc)? **YES NO** (If yes, please list all medications) \_\_\_\_\_
- Does the participant take any prescribed medication on a permanent basis or semi-permanent basis? **YES NO** (If yes, please list all medications) \_\_\_\_\_
- Has the participant been diagnosed or treated for any of the following conditions?

EPILEPSY	<b>YES</b>	<b>NO</b>	DIABETES	<b>YES</b>	<b>NO</b>	ANEMIA	<b>YES</b>	<b>NO</b>
ASTHMA	<b>YES</b>	<b>NO</b>	HEPATITIS	<b>YES</b>	<b>NO</b>	HEART MURMUR	<b>YES</b>	<b>NO</b>
AUTISM	<b>YES</b>	<b>NO</b>	SICKLE CELL ANEMIA	<b>YES</b>	<b>NO</b>	HIGH BLOOD PRESSURE	<b>YES</b>	<b>NO</b>
PNEUMONIA	<b>YES</b>	<b>NO</b>	RHEUMATIC FEVER	<b>YES</b>	<b>NO</b>	HERNIA	<b>YES</b>	<b>NO</b>
HEPATITIS	<b>YES</b>	<b>NO</b>	KIDNEY DISEASE	<b>YES</b>	<b>NO</b>	MONONUCLEOSIS	<b>YES</b>	<b>NO</b>
NECK INJURY	<b>YES</b>	<b>NO</b>	SKELETAL INJURY	<b>YES</b>	<b>NO</b>	HEAD INJURY	<b>YES</b>	<b>NO</b>
BROKEN/FRACTURED BONE	<b>YES</b>	<b>NO</b>	ULCER	<b>YES</b>	<b>NO</b>	JOINT INJURY	<b>YES</b>	<b>NO</b>
ARTHRITIS	<b>YES</b>	<b>NO</b>	CEREBAL PALSEY	<b>YES</b>	<b>NO</b>	MIGRAINE HEADACHE	<b>YES</b>	<b>NO</b>
MUSCULAR DYSTROPHY	<b>YES</b>	<b>NO</b>	ALS	<b>YES</b>	<b>NO</b>	AUTISM	<b>YES</b>	<b>NO</b>
ADD/ADHD	<b>YES</b>	<b>NO</b>	FOOD ALLERGY	<b>YES</b>	<b>NO</b>	OTHER ALLERGY (Insect, ragweed, etc)	<b>YES</b>	<b>NO</b>
GLASSES	<b>YES</b>	<b>NO</b>	CONTACT LENSES	<b>YES</b>	<b>NO</b>	POTTY TRAINED	<b>YES</b>	<b>NO</b>
DENTAL BRACES	<b>YES</b>	<b>NO</b>	DENTAL RETAINER	<b>YES</b>	<b>NO</b>	HEARING AID	<b>YES</b>	<b>NO</b>

If yes, please list all pertinent information regarding the diagnosis or treatment \_\_\_\_\_

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The information I have provided about the participant's medical history is accurate to the best of my knowledge. By my signature on the Atlanta Gymnastics Center registration form, I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition.