

Atlanta Gymnastics Center 2008 Camp Registration Form

Camp Session: _____ Date: _____
Camp Session: _____ Date: _____
Camp Session: _____ Date: _____
(use separate paper for additional sessions as needed and attach to registration form)

Early Drop Off: ___ Yes/___ No Late Pick Up: ___ Yes/___ No Camp Registration Deposit Fee (1/2 of total amount of each session): _____

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.

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

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

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.