

Atlanta Gymnastics Center 2010 Summer Camp Registration

Camp: _____	Week: _____	Deposit (1/2 of week): _____
Camp: _____	Week: _____	Deposit (1/2 of week): _____
Camp: _____	Week: _____	Deposit (1/2 of week): _____
Camp: _____	Week: _____	Deposit (1/2 of week): _____

Signify type of camp (Full Day, Half Day, My 1st, Mommy 'n Me, Team) and week/weeks of camp.
Please use another sheet if registering for more than four (4) weeks of summer camp.

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.

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 that future payments will be charged to my credit card: _____ Yes I decline future payments 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 MURMER	YES	NO
AUTISM SPECTRUM	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	MONONUCELOSIS	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	ADD/ADHD	YES	NO
FOOD ALLERGY	YES	NO	OTHER ALLERGY <small>(Insect, ragweed, etc)</small>	YES	NO	GLASSES	YES	NO
CONTACT LENSES	YES	NO	BLURRED VISION	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.