

TEAM CENTRAL GYMNASTIC ACADEMY

Cmptr	Different Last Name	Level	Fall/Wntr/Spr Class	Sum Class	Yearly Reg	R & P	Staff Initials
Student's Name _____		DOB ____/____/____		M	F	School _____	
Home Phone # _____		Medical/Physical Concerns _____			How Did You Hear About Us _____		
Parent/Guardian Information		Car/Beeper Phone # _____		e-mail _____			
Father's Name _____		Employer _____		Work Phone # _____			
Mother's Name _____		Employer _____		Work Phone # _____			
Home Address _____			City _____		State _____		Zip _____
Emergency Contact (other than parent) _____		Relationship _____			Phone # _____		
Doctor's Name _____				Phone # _____			

PERMISSION FOR MEDICAL TREATMENT: I confirm that the above named person is in good health. I hereby authorize simple first aid and consent to any x-ray, exam and medical or surgical diagnosis which is deemed necessary.

RELEASE: I hereby consent to have myself and/or my child/ward participate in programs offered by Team Central Gymnastic Academy. It is hereby agreed that I, my child(ren) adopted or otherwise, my executors, waive and release all rights and claims for damages that I may have at any against Team Central Gymnastic Academy, its representatives whether paid or volunteer for any injury or damages in connection with the Gymnastics program or other activities related to Gymnastics. The risks involved in respect to such a program are fully understood, as I have read the Rules & Policies Safety Statement.

I HEREBY GIVE PERMISSION FOR MEDICAL TREATMENT AND AGREE WITH THE RELEASE AS STATED ABOVE:

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

----- Office Use Only -----

Start Date _____ Trial _____ Check # _____ Dated _____ Amount _____ Payment For _____

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