Summer Class/Clinics Registration Form

Joel Baba's School of Gymnastics, Inc.

Gymnastics Class Desired Day _____ Time _____

Clinics Desired-*Check shaded box next to selected week(s)*

Week 1 7/8-7/11		Week 2 7/15-7/18		Week 3 7/22-7/25		Week 4 7/29-8/1		Week 5 8/5-8/8		Week 6 8/12-8/15		Week 7 8/19-8/22	

Student Name: _____

Date of Birth: _____

Address: _____

City/State/Zip: _____

Email: _____

Student Cell: _____ Home Phone: _____

Father's Name: _____ Father Cell: _____

Mother's Name: _____ Mother Cell: _____

Family Doctor: _____ Telephone: _____

Medical Conditions or Allergies:_____

In the event of a medical emergency, I give my permission for emergency medical staff to give my child treatment. Yes_____ No_____

WAIVER & RELEASE:

I AM FULLY AWARE OF, AND APPRECIATE THE RISK, INCLUDING SERIOUS INJURY, AS WELL AS OTHER DAMAGES & LOSSES ASSOCIATED WITH PARTICIPATION IN GYMNASTICS & OR OTHER ACTIVITY. I FURTHER AGREE JOEL BABA'S SCHOOL OF GYMNASTICS ALONG WITH EMPLOYEES & DIRECTORS SHALL NOT BE LIABLE FOR ANY LOSSES, INJURIES, OR DAMAGES AS A RESULT OF MY CHILD'S PARTICIPATION IN THESE EVENTS.

Parent Printed Name: _____ Date: _____

Parent Signature: _____