2025 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 7/7-7/10		Week 2 7/14-7/17		Week 3 7/21-7/24		Week 4 7/28-7/31		Week 5 8/4-8/7		Week 6 8/11-8/14		Week 7 8/18-8/21	

Student Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Email: _____

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.

Payments need to be made prior to classes/ clinics being taken. If no tuition is paid, a student will not be allowed to participate until the account is up to date.

Parent Printed Name: _____ Date: _____

Parent Signature: _____