***REBOUND THERAPY REGISTRATION FORM***

Flipz Tumbling

Tel: 605-949-0757

Email: flipz.tumbling@yahoo.com

Please fill out this form and return it to Flipz Tumbling with payment in full to secure your spot(s).

**FAMILY INFORMATION:**

Parent’s Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_

Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alt Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARTICIPANTS INFORMATION:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_ M/F

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_ M/F

CARETAKERS INFORMATION: (NOTE THIS IS WHO WILL BE ACCOMPANYING THE PARTICIPANT TO CLASS AND MUST BE 18 YEARS OR OLDER)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_ M/F

Participant History:

\*\*Please check any that the participant currently has:

Spinal Rodding Dwarfism Brittle Bone Disease Pregnancy Detached Retina(s)

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Antlanto-Axial Instability(confirmed by physician) Vertebral Body Tethering(VBT)

Osteoporosis Hemophilia Cardiac/Circulatory Issues Epilepsy Arthritis/Stills Disease

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Asthma/Respiratory Issues Cystic Fibrosis Muscular Dystrophy Spina Bifida

Hydrocephalus Hypertonia Hypotonia Developmental dysplasia of the hip(DDH)

Vertigo Drop Attacks Nausea Hernia Open wounds Gastrostomy

Incontinence Tracheostomy Implant(ex: baclofen pump) None of the above

**Please list past medical diagnoses that we should know about (if any):**

**What are your primary goals for your Wellness or Rebound Therapy sessions?**

**Please list anything else you would like us to know:**

Payment: Cash/Check/Venmo: @Tiffany-Wellnitz

**Payments due at signup or your child will not be able to attend. Please contact Tiffany if there are any payment concerns. There will be a $30.00 fee for insufficient funds.**