SUMMER CAMP REGISTRATION 2020

Student's last name _____, First name_____

Student Age ____DOB___/___/____

Already enrolled in a class at Omega? Yes___ NO____ If answer is "NO" please fill out the following.

Parent/Guardian Name_____

Email Address_____

Home Phone_____ Cell Phone_____

Parent's Work Place_____ Phone_____

Emergency contact_____ Phone_____

Please check the week or weeks your child will be attending:

FULL DAY CAMPS 5 DAY$250/ 4DAY $190	
5 DAY- JUNE 8 – 12	_____
5 DAY- JUNE 22- 26	_____
4 DAY-JULY 6 – 9	_____
4 DAY JULY 20 – 23	_____
4 AUGUST 3 – 6	_____
CHEER CAMP	
4 DAY JULY 13- 16	_____

HALF DAY CAMPS 5 DAY $160 / 4DAY $130	
5 DAY- JUNE 8 – 12	_____
5 DAY- JUNE 22- 26	_____
4 DAY-JULY 6 – 9	_____
4 DAY JULY 20 – 23	_____
4 AUGUST 3 – 6	_____

Early Drop off 8:00Am ($20.00) _____ Late Pick up 5:00pm ($20.00) _____

*A $50.00 non-refundable deposit PER camp is due at time of registration along with registration form
*Balance is due no later than Thursday, the week before their camp

Waiver of Liability:

ANY ACTIVITY INVOLVING HEIGHT OR MOTION INCURS THE POSSIBILITY OF ACCIDENTAL INJURY. WHILE IT IS OUR EXPRESS INTENTION AT OMEGA GYMNASTICS, INC. TO PROVIDE FOR THE SAFETY AND PROTECTION OF YOUR CHILD, IT IS EXPRESSLY ASSERTED THAT OMEGA GYMNASTICS, INC. SHALL NOT BE HELD LIABLE FOR ANY INJURY SUSTAINED WHILE YOUR CHILD IS UNDER OUR INSTRUCTION, SUPERVISION, OR CONTROL.

_____ _____
Parent/Guardian Signature Date

Full Day Campers: (Note parents are responsible to drop off a car seat if their child requires one.)

I, the parent/guardian of _____, hereby give permission for my child to ride in the vehicle provided by Omega Gymnastics, Inc.

_____ _____
Parent/Guardian Signature Date

Medical History Form (for new customers only)

Health History

Please check "X" for any items listed below which apply to your child.

____ DIABETES
____ HEART MURMUR
____ HIGH BLOOD PRESSURE
____ HEART DISEASE
____ SIGHT DIFFICULTIES
____ EYE GLASSES OR CONTACT LENSES
____ DENTAL APPLIANCE
____ CURRENTLY ON MEDICAION
____ ASTHMA
____ ANEMIC
____ FREQUENT NOSE BLEEDS
____ FAINTING SPELLS
____ CONVULSIONS
____ SEIZURES
____ HEARING DIFFICULTIES
____ ARTHRITIS
____ ALLERGIC REACTIONS BUG BITES

PLEASE IDENTIFY MEDICATIONS/ALLERGIES_____

IN THE PAST THREE YEARS HAS ANY OF THE FOLLOWING OCCURRED? IF SO, PLEASE GIVE DATE AND EXPLANATION.

____ FRACTURE (BROKEN BONES)
____ DISLOCATION
____ SPRAINS
____ BACK OR NECK INJURY
____ CONCUSSION
____ SURGERY
____ ANKLE PROBLEM
____ KNEE PROBLEM
____ ELBOW PROBLEM
____ WRIST PROBLEM
____ FOOT PROBLEM
____ EXTENDED ILLNESS

HAS YOUR CHILD HAD CHICKEN POX? _____YES_____NO

NAME OF PHYSICAN_____

INSURANCE COMAPANY_____POLICY NUMBER_____

Camp?										
Date										
Amt Pd										
Form of Pmt										
Balance										