

# 2009 / 2010

## GYMNASTICS CENTRAL STUDENT INFORMATION FORM

Office use  
Date filed: \_\_\_\_\_  
FAMILY LAST NAME \_\_\_\_\_

FAMILY LAST NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

HOME PHONE ( \_\_\_\_\_ ) \_\_\_\_\_ City, State ZIP

Please check if family information has changed.

### PARENTS NAMES (if student is under 19)

Mother: \_\_\_\_\_ first \_\_\_\_\_ last

Business phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Father: \_\_\_\_\_ first \_\_\_\_\_ last

Business phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

### Child 1

\_\_\_\_\_  Male  Female \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_  
Name (first, last) Date of birth:

This person is allergic to: \_\_\_\_\_

This person takes the following medication: \_\_\_\_\_ Purpose: \_\_\_\_\_

This person has the following disabilities: \_\_\_\_\_

Please list any activities which you feel are not appropriate for this child: \_\_\_\_\_

### Child 2

\_\_\_\_\_  Male  Female \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_  
Name (first, last) Date of birth:

This person is allergic to: \_\_\_\_\_

This person takes the following medication: \_\_\_\_\_ Purpose: \_\_\_\_\_

This person has the following disabilities: \_\_\_\_\_

Please list any activities which you feel are not appropriate for this child: \_\_\_\_\_

### Child 3

\_\_\_\_\_  Male  Female \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_  
Name (first, last) Date of birth:

This person is allergic to: \_\_\_\_\_

This person takes the following medication: \_\_\_\_\_ Purpose: \_\_\_\_\_

This person has the following disabilities: \_\_\_\_\_

Please list any activities which you feel are not appropriate for this child: \_\_\_\_\_

### Alternate adult contact:

If unable to reach parent, contact \_\_\_\_\_ Name \_\_\_\_\_ Phone \_\_\_\_\_ relationship \_\_\_\_\_

Family physician: \_\_\_\_\_ Name \_\_\_\_\_ Phone \_\_\_\_\_ Dr.'s Hospital association \_\_\_\_\_

Insurance company: \_\_\_\_\_ Policy (or group) number: \_\_\_\_\_

\*\*\*Your personal health insurance is responsible for the hospital and physician costs incurred if you become injured or ill in the gym or at a club sponsored event and require the service of a physician.

**THIS FORM MUST BE COMPLETED  
BEFORE YOUR CHILD IS ALLOWED  
TO PARTICIPATE**

**GYMNASTICS CENTRAL  
RELEASE FORM 2009 / 2010**

Students' name(S): \_\_\_\_\_

**MINOR WAIVER / RELEASE (Complete if students are under 18 years by parent or guardian)**

**MINOR WAIVER/RELEASE** (Complete if students are under 18.)

I understand the sports of gymnastics, dance, tumbling, etc. involves certain inherent risks, notwithstanding the safety precautions which are taken. I assume such risks in behalf of my child. In consideration of your accepting my child as a student in your program, for myself, my heirs, my executors, administrators, and assigns, I waive and release any and all rights and claims for damages I have against Gymnastics Central, LLC., its sponsors, agents, employees, representatives, successors, and assigns, (hereinafter collectively termed G.C), for any and all injuries and losses suffered by my child and/or me and agree to indemnify and hold harmless G.C. for any claims by me or my child arising out of participation in any program or otherwise at G.C. or at any other location during an event sponsored by G.C. Additionally, I hereby grant G.C. permission to render first aid emergency treatment which it considers necessary to my child while in attendance at G.C., or at any other location during an event sponsored by G.C. and release all rights and claims for damages which said child or I may have against G.C. in connection with the rendering of said first aid emergency treatment

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian)

**Consent for treatment for accident & illness**

**CONSENT FOR TREATMENT FOR ACCIDENT & ILLNESS**

Hospitals require that parents or adult guardians must give written consent before treatment of a "minor" (person under the age of 18) may begin

U n l e s s t h e s i t u a t i o n i s l i f e t h r e a t e n i n g .

I understand that G.C.is not responsible in matters of illness or accidents. I certify that my child has had a medical examination to assure physical fitness and capability to perform the Gymnastics, dance, or cheerleading involved in the programs offered by G.C. In the event of any emergency, I hereby give permission to the licensed physician selected by G.C. to hospitalize, secure proper treatment, a n e s t h e s i a , o r s u r g e r y f o r m y c h i l d . ( I n t h i s l o c a t i o n , G y m n a s t i c s C e n t r a l w i l l c o n t a c t M e r c y A n d e r s o n H o s p i t a l . )

Child's Name \_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_\_\_\_  
Child's Name \_\_\_\_\_ (Parent or Guardian)  
Child's Name \_\_\_\_\_

**ADULT WAIVER / RELEASE**

(sign only if the parent accompanies the child into the gym, or if adult classes are being taken)

I understand the sport of gymnastics involves some inherent risks, notwithstanding the safety precautions which are taken. I assume such risks. In consideration of your accepting me as a student in your program, for myself, my heirs, executors, administrators, and assigns, I waive and release any and all rights and claims for damages I have against Gymnastics Central, LLC, its sponsors, agents, employees, representatives, successors and assigns, (herein after collectively termed G.C.), for any and all injuries and losses suffered by me at G.C. Additionally, I hereby grant G.C. permission to render first aid emergency treatment which it considers necessary to me in the event that I am physically unable to give consent as a result of an injury while in attendance at G.C. and release all rights and claims for damages

Signed \_\_\_\_\_ Date \_\_\_\_\_