



ANNUAL REGISTRATION FORM - ANNUAL FEE PER FAMILY \$50.00

Welcome to the Ocean State School of Gymnastics Center. Please fill this form in completely and return to the office.

How did you hear about us? \_\_\_TV \_\_\_Internet \_\_\_Friend \_\_\_Radio \_\_\_Phone Book \_\_\_Print ad

My name \_\_\_\_\_ DOB \_\_\_\_\_ Parent 2 \_\_\_\_\_ DOB \_\_\_\_\_

Street \_\_\_\_\_ Street \_\_\_\_\_

City, St., Zip \_\_\_\_\_ City, St., Zip \_\_\_\_\_

Phone \_\_\_\_\_ Cell \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_ Email \_\_\_\_\_

Child 1 \_\_\_\_\_ DOB \_\_\_\_\_ Gymnast \_\_\_ Rock Climber \_\_\_

Child 2 \_\_\_\_\_ DOB \_\_\_\_\_ Gymnast \_\_\_ Rock Climber \_\_\_

Child 3 \_\_\_\_\_ DOB \_\_\_\_\_ Gymnast \_\_\_ Rock Climber \_\_\_

Child 4 \_\_\_\_\_ DOB \_\_\_\_\_ Gymnast \_\_\_ Rock Climber \_\_\_

Notify in case of emergency: Name \_\_\_\_\_ Phone \_\_\_\_\_

Any outstanding history or condition? \_\_\_\_\_

Daily medications? \_\_\_\_\_

Allergies? \_\_\_\_\_

Club Waiver and Release

I give permission for my child to participate in gymnastics/rock climbing or swimming at the Ocean State School of Gymnastics Center. I understand that gymnastics, rock climbing and swimming can be dangerous. I accept that any activity involving motion, height or water activity can cause serious, or catastrophic injury. The above named participants have had a medical examination within the last twelve months and are physically, mentally and emotionally capable of participating in athletic activities. Participants are expected to carry their own accident and medical insurance. I agree to be responsible for any medical bills incurred resulting from illness or injury while my child is at OSSG. In the event of injury or illness, every effort will be made to contact the parents or guardian. If necessary, I authorize emergency medical treatment for any of the above named family members if he/she should be injured while participating in one of our programs. I understand that an effort will be made to contact me prior to treatment. If I cannot be reached, or the emergency person cannot be reached, I give my permission to the emergency medical technician staff, the hospital and the attending physicians to render emergency care. I also understand that the hospital will continue to attempt to reach me or a designated guardian until one of us has been contacted.

For rock climbing:(under age 14)

I prefer my children to wear a helmet \_\_\_\_\_ (Initial)

My children may climb without a helmet \_\_\_\_\_ (Initial)

I have read the above waiver and release and understand and agree with it completely.

Parent or Guardian signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(date registered)

(last name)