Ocean State School of Gymnastics

Summer Camp Registration Form

Parents Information:

Parents Name: _____

Address: _____ City:_____ RI: ____ ZIP: _____

Home Phone:_____ Cell Phone:_____ Email: _____

Child/Children Information:

Child 1: _____ DOB _____

Med. Conditions/Allergies/Daily Meds: _____

Helmet for Rock Climbing: ___ Yes ___ No **(all preschool campers are required to wear a helmet)**

Child 2: _____ DOB _____

Med. Conditions/Allergies/Daily Meds: _____

Helmet for Rock Climbing: ___ Yes ___ No (all preschool campers are required to wear a helmet)

Child 3: _____ DOB _____

Med. Conditions/Allergies/Daily Meds: _____

Helmet for Rock Climbing: ___ Yes ___ No (all preschool campers are required to wear a helmet)

Flotation Device For Swimming: All Campers under 54 inches are required to wear a flotation device.

Emergency Contact Information:

Emergency Contact 1: _____

Relationship: _____ Phone Number: _____

Emergency Contact 2: _____

Relationship: _____ Phone Number: _____

Emergency Contact 3: _____

Relationship: _____ Phone Number: _____

Authorized to Pick Up My Child (please use back for additional names):

Name: _____ Relationship: _____

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 your 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.

Parent or Guardian Signature: _____ Date: _____