

NOVAKS' SUMMER CAMP REGISTRATION FORM

CAMPER INFORMATION

Name _____ Age _____ Birthdate _____ Sex _____
Last First Middle at time of camp MM/DD/YY

Current Novaks' Member? YES NO CURRENT CLASS/LEVEL _____

Parent/Guardian Names _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Pphone (____) _____

Cell Phone (____) _____ Other Phone (____) _____

Health Insurance _____ Policy # _____

ALLERGIES/MEDICAL CONCERNS _____

MEDI CATION/ VI TAMI NS? _____

EMERGENCY CONTACT INFORMATION

To be contacted when parent cannot be reached

Name _____ Relationship _____

Phone (____) _____ Phone (____) _____

Session Choice: Week # _____ Dates: _____

↑ **** PLEASE INDICATE SESSION CHOICE **** ↑

I hereby grant permission for my child to participate in the program's at Novaks' Gymnastic Center Inc. summer camp during the selected dates above. In the event I cannot be reached readily in an emergency, Novaks' employee's have the authority, at my expense to utilize the most available volunteer rescue squad or ambulance to transport my child to the nearest hospital and, if necessary, to authorize medical treatment. I hereby certify that the child has passed a medical examination within the last (12) twelve months and is capable of participating in the sport of gymnastics and/or tumbling and/or trampoline. I understand I must supply Novaks' with a copy of my child's physical examination, signed by a physician before he/she will be allowed to participate. In addition to the physical exam, I will also provide Novaks' Gymnastic Center with a copy of our medical insurance card.

I realize that gymnastics, tumbling and trampoline involves the risk of serious injury, even death, and I release Novaks' Gymnastic Center, Inc. and it's employee's from any and all liability which might be incurred during the conduct of this activity. I will explain the rules, policies and behavior expectations of Novaks' Gymnastic Centers summer camp to my child(ren).

Parent/Guardian Signature _____ Date _____

↓ OFFICE USE ONLY ↓

Deposit	Date Paid	Ck#/ Cash

Balance	Date Paid	Ck#/Cash

Medical insurance card	<input type="checkbox"/>
Physical form (signed by Dr).	<input type="checkbox"/>