## *ATHLETIC HORIZONS GYMNASTICS CENTER*

***MEDICAL TREATMENT INFORMATION***
***Please Print .Fill in all Information and sign both front and back.*** ***2010-2011***

***Student's First Name***

***Student's Last Name***

**Student's Birth Date**
**( Month / Date / Year)**

***Address***

***City*** ***State*** ***Zip Code***

***Mother's First Name***

***Mother's Last Name***

***Home Phone*** ***Business Phone*** ***Fax***

***Cell Phone*** ***Pager Phone*** ***Pager Code***

***E-Mail***

***Father's First Name***

***Father's Last Name***

***Home Phone*** ***Business Phone*** ***Fax***

***Cell Phone*** ***Pager Phone*** ***Pager Code***

**RELATIVE OR FRIEND TO CONTACT IN CASE OF EMERGENCY OTHER THAN PARENT**

***Name*** ***Last Name*** ***Phone***

- **Has participant had any serious illness, surgery or injury? NO ___ YES ___**
  **Describe:**
  _____
- **Does participant take regular medication? NO____ YES____**
  **If YES, what medication?**
  _____
- **List allergies or sensitivities**
  _____
- **Family Doctor_____ Phone _____**
- **Health Insurance Company _____ Policy # _____**
- **Are there any physical conditions our staff should be aware of when teaching your child gymnastics?**
  _____

### AGREEMENT TO PARTICIPATE

- **ASSUMPTION OF RISK: Participation in gymnastics activities involves motion, rotation and height in a unique environment and as such carries with it a certain assumption of risk. Due to the nature of the sport, participation could result in catastrophic injury.**
  **We, the parents/guardians of _____give my/our approval for his/her participation in the Athletic Horizons Gymnastics program, and assume all risks and hazards incidental to the conduct of the gymnastics program and transportation to and from the activity.**
- **It is further understood that Athletic Horizons will not provide individual medical insurance. I/We will assume full responsibility for medical costs should injury occur. I confirm the participant is in good health, and listed above are any special conditions that should be noted to Athletic Horizons staff.**
- **If an emergency arises which should require immediate medical attention, and we as parents/guardians cannot be contacted, you are authorized to take whatever steps are needed to protect the health of this student.**
  **This authorization will remain effective while the above student is involved or participating in any Athletic Horizons program or activity, unless revoked in writing by the undersigned and delivered to the aforesaid agent.**

**PARENT/GUARDIAN_____ DATE_____**

**(OVER)**