Panhandle Gymnastics

GROUP ENROLLMENT FORM

CONTACT DETAILS

Group Leader Name(s)_____**OFFICE USE CLASS:_____**

Group/Organization Name:_____

Address:_____ City/St_____ Zip_____

Group/Organization Role:_____ Phone (Cell):_____

Email Address:_____ Phone:_____

Preferred Method of Contact: Phone Call Text Email

STUDENT INFORMATION

1) Child Name:_____ Date of Birth___/___/___ Male/Female

Does child have any medical conditions, allergies or sensitivities including Asthma, Anaphylaxis, Epilepsy, and/or Diabetes? ___Yes ___No

If yes please explain:_____

General Information: Is there any other information that may affect your child's gymnastics experience? For example fear of heights, previous injuries, other medical or physical conditions.

If yes please explain:_____

2) Child Name:_____ Date of Birth___/___/___ Male/Female

Does child have any medical conditions, allergies or sensitivities including Asthma, Anaphylaxis, Epilepsy, and/or Diabetes? ___Yes ___No

If yes please explain:_____

General Information: Is there any other information that may affect child's gymnastics experience? For example fear of heights, previous injuries, other medical or physical conditions.

If yes please explain:_____

3) Child Name:_____ Date of Birth___/___/___ Male/Female

Does child have any medical conditions, allergies or sensitivities including Asthma, Anaphylaxis, Epilepsy, and/or Diabetes? ___Yes ___No

If yes please explain:_____

General Information: Is there any other information that may affect child's gymnastics experience? For example fear of heights, previous injuries, other medical or physical conditions.

If yes please explain:_____

4) Child Name:_____ Date of Birth___/___/___ Male/Female

Does child have any medical conditions, allergies or sensitivities including Asthma, Anaphylaxis, Epilepsy, and/or Diabetes? ___Yes ___No

If yes please explain:_____

General Information: Is there any other information that may affect child's gymnastics experience? For example fear of heights, previous injuries, other medical or physical conditions.

If yes please explain:_____

5) Child Name:_____ Date of Birth___/___/___ Male/Female

Does child have any medical conditions, allergies or sensitivities including Asthma, Anaphylaxis, Epilepsy, and/or Diabetes? ___Yes ___No

If yes please explain:_____

General Information: Is there any other information that may affect child's gymnastics experience? For example fear of heights, previous injuries, other medical or physical conditions.

If yes please explain:_____

6) Child Name:_____ Date of Birth___/___/___ Male/Female

Does child have any medical conditions, allergies or sensitivities including Asthma, Anaphylaxis, Epilepsy, and/or Diabetes? ___Yes ___No

If yes please explain:_____

General Information: Is there any other information that may affect child's gymnastics experience? For example fear of heights, previous injuries, other medical or physical conditions.

If yes please explain:_____

7) Child Name:_____ Date of Birth___/___/___ Male/Female

Does child have any medical conditions, allergies or sensitivities including Asthma, Anaphylaxis, Epilepsy, and/or Diabetes? ___Yes ___No

If yes please explain:_____

General Information: Is there any other information that may affect child's gymnastics experience? For example fear of heights, previous injuries, other medical or physical conditions.

If yes please explain:_____

8) Child Name:_____ Date of Birth___/___/___ Male/Female

Does child have any medical conditions, allergies or sensitivities including Asthma, Anaphylaxis, Epilepsy, and/or Diabetes? ___Yes ___No

If yes please explain:_____

General Information: Is there any other information that may affect child's gymnastics experience? For example fear of heights, previous injuries, other medical or physical conditions.

If yes please explain:_____

9) Child Name:_____ Date of Birth___/___/___ Male/Female

Does child have any medical conditions, allergies or sensitivities including Asthma, Anaphylaxis, Epilepsy, and/or Diabetes? ___Yes ___No

If yes please explain:_____

General Information: Is there any other information that may affect child's gymnastics experience? For example fear of heights, previous injuries, other medical or physical conditions.

If yes please explain:_____

10) Child Name:_____ Date of Birth___/___/___ Male/Female

Does child have any medical conditions, allergies or sensitivities including Asthma, Anaphylaxis, Epilepsy, and/or Diabetes? ___Yes ___No

If yes please explain:_____

General Information: Is there any other information that may affect child's gymnastics experience? For example fear of heights, previous injuries, other medical or physical conditions.

If yes please explain:_____

Emergency Contact (Must be different from Group/Organization Leader(s))

Name:_____ Relationship to Group/Organization:_____

Phone #1_____ Phone #2_____

AUTHORIZATION FOR DROP OFF/PICK UP:

Please list any and all persons authorized to drop off and pick up your children other than the Group/Organization Leader Name(s) listed on this form.

_____

_____

FORMS/ SIGNATURES:

Please initial beside each of the following you have read and/or understood, and have signed if necessary:

_____ Panhandle Gymnastics Group/Organization Policies

_____ Release and Waiver of Liability (One per child)

_____ USAG Level Requirements

_____ USAG Safe Sport Policy

Print Name:_____ Date:_____

Signature:_____