

AGT FLIP CITY

Date: _____ Referred by: _____

Child's Name: _____

Last

First

Home Phone# _____ Date of Birth: _____

Address: _____

Street

City

Zip

Mother's Name: _____

Work # _____ Cell Phone # _____

Father's Name: _____

Work # _____ Cell Phone # _____

Email address: _____

Emergency Contact: _____

Relationship: _____ Phone # _____

Emergency Treatment Form

To whom it may concern:

As a parent and/or legal guardian of _____, a minor I herewith authorize treatment by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Physician: _____ Phone# _____

Specific medical allergies, chronic illness or other medical conditions staff should be aware of:

This form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signature: _____ Date: _____

OFFICE USE ONLY

Class: _____ Day: _____ Time: _____

Paid Reg. Fee: _____ Class Fee: _____ Try out Fee: _____

ACKNOWLEDGEMENT OF RISK AND WAIVER OF LIABILITY

As parent or legal guardian of _____, I hereby consent to the aforementioned person participating in the AGT Flip City programs. I recognize that potentially severe injuries, including but not limited to , permanent paralyses or death can occur in any activity involving height or motion, including dance, gymnastics and related activities on gymnastics apparatus including trampoline and tumble track.

I understand that it is the express intent of AGT Flip City to provide for the safety and protection of my child and in consideration for allowing my child to use these facilities. I hereby forever release AGT Flip City, its officers, employees, teachers and coaches from all liability for any and all damages and injuries suffered by my child while under the instruction, supervision or control of AGT Flip City.

As legal guardian of the aforementioned person, I hereby agree to individually provide for the possible future medical expenses which may be incurred by my child as a result of any injury sustained while training at, or performing for AGT Flip City.

This acknowledgement of risk and waiver of liability, having read and thoroughly and understand completely, is signed voluntarily to its control and intent.

Signature of Parent of legal guardian Date

AGT Flip City Policies

1. Payment is expected the first day of each session. A \$5.00 late fee will be assessed if payment is late.
2. One missed class per session is allowed to be made up. This make-up is the last Saturday of the month unless otherwise notified.
3. Drop-out: A two week notice is required to discontinue billing. Status change forms are available at the front desk.
4. NO REFUNDS for anyone for any reason.

Signature of Parent of legal guardian Date