Open Gym

AWTT

www.allworld-gym.com

Date:_____ **Referred by:**_____

Childs Name:_____
Last First

Home Phone No._____ Date Of Birth:_____

Address:_____
Street City Zip

Mothers Name:_____

Work No._____ Cell Phone:_____

Fathers Name:_____

Work No._____ Cell Phone:_____

Emergency Contact:_____

Relationship:_____Phone:_____

EMERGENCY TREATMENT FORM

To whom it may concern:
As a parent and/or 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 No_____
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 pupose 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:_____
Scan Card #_____
EMAIL ADDRESS: _____