TWISTERS GYMNASTICS & TRAMPOLINE CLUB

275 Alder Street, Orangeville, ON, L9W 5H6
519-942-2477

REGISTRATION FORM

SURNAME OF PARTICIPANT	FIRST NAME	MALE FEMALE	BIRTHDATE (M/D/Y)

ADDRESS (STREET/PO BOX)

CITY/TOWN	PROVINCE	POSTAL CODE	TELEPHONE NO.

NAME OF PARENT/GUARDIAN	RELATIONSHIP	CELL PHONE NO.

PARENT EMAIL ADDRESS	EMERGENCY CONTACT	TELEPHONE NO.

DOES THE PARTICIPANT HAVE ANY PHYSICAL, MENTAL OR MEDICAL CONDITIONS THAT, FOR SAFETY REASONS SHOULD BE DISCLOSED?
NO_____ YES_____ EXPLAIN:

If your child has special needs (down syndrome, autism) a separate form will need to be completed

HAS THE PARTICIPANT EVER HAD AN INJURY OR ACCIDENT REQUIRING ONGOING MEDICAL ATTENTION?
NO_____ YES_____ SPECIFY:

HAS THE PARTICIPANT EVER HAD SURGERY?
NO_____ YES_____ SPECIFY:

PARENT/GUARDIAN CONSENT OF PARTICIPATION AND WAIVER

By submitting and signing this form I acknowledge that I am aware that there are risks with gymnastics. I warrant that the participant named on this information form, is physically fit to participate in gymnastics. I declare that I have accurately disclosed all information regarding physical, mental or medical conditions affecting the named participant and acknowledge that this information will be used for the club/GO's use in the delivery of a gymnastic program. I acknowledge that there is potential risk for injury involved in training and competing in any sport. I understand that the Gymnastics Ontario has tried to create a safe and controlled environment for participation and that the club established rules for participation on and about the gymnastic area that must be followed by the participant at all times. I understand that failure to comply to any of the policies and rules of the club and/or GO may result in the termination of membership and waive the rights of the participant to damages or other costs in the event injury is caused due to participation in gymnastics or other involvement with the Federation.

I hereby give permission for emergency medical treatment to be administered to my son/daughter, as may be determined in the reasonable discretion of the Coach/Supervising Coach. It is understood that whenever reasonably possible, Emergency Contact person or Parent will be contacted and informed of the problem and required medical treatment.

I understand that it is my responsibility to ensure that the information on this form is kept current and I will notify the Club of any changes immediately.

SIGNATURE OF PARENT	DATE (M/D/Y)

CHQ NO.	CASH/DEBIT	M/C	VISA	CLASS	DAY M T W T F S S	TIME