NOVAKS' SUMMER CAMP REGISTRATION FORM

CAMPER INFORMATION

Name_____Age____Birthdate_____Sex____
Last First Middle at time of camp MM/DD/YY

Current Novaks' Member? YES NO CURRENT CLASS/LEVEL_____

Parent/Guardian Names_____
Address_____City_____State____Zip_____
Home Phone (____)_____ Work Pphone (____)_____
Cell Phone (____)_____ Other Phone (____)_____

Health Insurance_____Policy #_____

ALLERGIES/MEDICAL CONCERNS_____
MEDICATION/ VITAMINS?_____

EMERGENCY CONTACT INFORMATION

To be contacted when parent cannot be reached

Name_____Relationship_____

Phone (____)_____ Phone (____)_____

Session Choice: **Week #1** ***Aug 3 - Aug 9*** **Week #2** **Aug. 10 - Aug 16** **Week #3** **Aug 17 - Aug 23**

PLEASE CIRCLE SESSION CHOICE

I hereby grant permission for my child to participate in the program's at Novaks' Gymnastic Center Inc. summer camp during the selected dates above. In the event I cannot be reached readily in an emergency, Novaks' employee's have the authority, at my expense to utilize the most available volunteer rescue squad or ambulance to transport my child to the nearest hospital and, if necessary, to authorize medical treatment. I hereby certify that the child has passed a medical examination within the last (12) twelve months and is capable of participating in the sport of gymnastics and/or tumbling and/or trampoline. I understand I must supply Novaks' with a copy of my child's physical examination, signed by a physician before he/she will be allowed to participate. In addition to the physical exam, I will also provide Novaks' Gymnastic Center with a copy of our medical insurance card.
I realize that gymnastics, tumbling and trampoline involves the risk of serious injury, even death, and I release Novaks' Gymnastic Center, Inc.and it's employee's from any and all liability which might be incurred during the conduct of this activity. I will explain the rules, policies and behavior expectations of Novaks' Gymnastic Centers summer camp to my child(ren).

Parent/GuardianSignature _____ Date_____

OFFICE USE ONLY

Deposit	Date Paid	Ck#/ Cash

Balance	Date Paid	Ck#/Cash

Medical insurance card ☐

Physical form (signed by Dr). ☐