ISG GYMNASTICS

Summer Program Emergency/Medical Form 2017

Date _____

Name _____ DOB _____

Address _____ Age _____ Male / Female

City, State, Zip _____ Mother's pref # _____

Home # _____ Father's pref # _____

Contact in case of emergency (other than parents)

1. Name _____ Relationship _____ Phone _____
2. Name _____ Relationship _____ Phone _____

Please state any information which will be of significance to us. Include any physical, educational, or psychological handicaps, limitations, special treatment, allergies, dietary restrictions, medications, etc that can help us better care for or understand your child.

_____

_____

_____

I do hereby give the authority to ISG to obtain necessary emergency medical treatment for my child in the event that the parent cannot be reached, with the understanding that the family will be notified as soon as possible.

Signed (by parent or guardian) _____

Printed _____

Phone _____

Address _____

_____