**CRESCENT CITY GYMNASTICS**

**SUMMER CAMP**

**Please PRINT all information.**

Athlete Name:

Age: DOB:

Address:

City, State, Zip:

Parent / Guardian:

Phone:

Email:

**Emergency Contact:**

Name:

Address:

City, State, Zip:

Phone:

Email:

**Please CIRCLE ALL WEEKS ATTENDING:**

Week 1 Week 6 *Week 11:*

Week 2 Week 7 *Cheer Camp ONLY*

Week 3 Week 8 *(Inquire within)*

Week 4 Week 9

Week 5 Week 10

**Please CIRCLE ONE:**

FULL days HALF days

**Please CIRCLE ONE: Before/After Care (optional):**

Daily ($15) Dates: Weekly ($50)

**T-Shirt size:**

**OFFICE USE ONLY:**

Total sessions: Amount Due:

Amount PD: Balance Due:

PD by:

Cash # Card #

In consideration of my participation in the Crescent City Gymnastics Summer Camp,

I, , on behalf of myself, my heirs, legatees personal representatives, and all those claiming by or through me, consent to, and so hereby discharge and release and forever hold harmless Crescent City Gymnastics and their affiliates, sponsors, agents, servants, employees, assigns, successors, heirs and any facility at which events are held, from any and all claims, actions, losses, damages or expenses for personal or bodily injury (including death), and property loss or damage of whatever nature or cause, incurred by me or arising out of or in any conjunction with my consent. I am of legal age and capacity and have read and understand the contents of this consent and release. If minor, signature of parent or guardian required.

**Signature**

**EMERGENCY HOSPITAL PERMISSION:**

I hereby give my permission to any adult at Crescent City Gymnastics to drive my child to the emergency room of Touro Hospital in the event of a medical emergency.

**Signature**

If Touro Hospital is not your preferred hospital, please provide the name of your preferred hospital below.

**ALLERGIES:** Please list below any allergies or special medical information for your child. *NOTE: Please do not bring your child to camp if they are sick. Medication cannot be administered by CCG staff.*