

Flippers Gym Program 2011-2012 Registration Form

Child's Name _____ Age _____ Birthdate _____

Address _____ City _____ Zip _____

Phone _____ Cell Phone _____

Emergency Contact and Phone _____

Email _____

Relevant medical information _____

Doctor/Phone _____

Dentist/Phone _____

Medical Specialist/Phone _____

In the event reasonable attempts to contact my emergency contact and/or me have been unsuccessful, I hereby give my consent for (1) the administration of any medical treatment deemed necessary by above named doctor or dentist, or, in the event the designated preferred practitioner is not available, by another licensed doctor or dentist; and (2) the transfer of myself and/or my child to any hospital reasonably accessible.

Acknowledged and Agreed: *(please sign twice)*

Parent/Guardian signature
(On behalf of participant)

Parent/Guardian signature
(Individually and as parent/guardian)

Date