

Class \_\_\_\_\_  
Day \_\_\_\_\_  
Time \_\_\_\_\_

# Desert Thunder

Registration Form  
Updated 1-26-2012

Student's Name \_\_\_\_\_  
Last First

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F

Mother's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

E-Mail \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency contact: Name \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

## **ACKNOWLEDGEMENT OF RISK AND WAIVER OF LIABILITY AND AGREEMENT NOT TO SUE**

As a parent/legal guardian of \_\_\_\_\_, hereby give consent for him/her to participate in Desert Thunder Gymnastics programs. I recognize that potentially severe injuries can occur in any activity, including gymnastics, which involves height and motion. I realize that my child will be training and performing on all gymnastics apparatus and events, plus other training devices, including trampoline.

I understand it is the intent of Desert Thunder Gymnastics to provide for the safety and protection of my child. And in consideration for allowing my child to use these facilities, I hereby release Desert Thunder Gymnastics, its officers, employees, coaches, and staff from all liability from any and all damages and/or injuries while under the instruction, supervision, or care of Desert Thunder Gymnastics and its employees.

I agree to provide for medical expenses incurred by this person as of any injury sustained while training or performing at or for Desert Thunder Gymnastics. I hereby authorize Desert Thunder Gymnastics to seek medical treatment, in the event that I cannot be reached.

I certify that my child is in good physical condition and is capable of participating on the Desert Thunder Gymnastics program. Please list any medical conditions we should be aware of: \_\_\_\_\_

This Acknowledgement of Risk and Waiver of Liability and agreement not to sue, has been read thoroughly and understood fully as to its content and intent, and is being signed voluntarily. **I have read, understand and agree to the policies laid out by Desert Thunder Gymnastics.**

Parent/legal guardian \_\_\_\_\_ Date \_\_\_\_\_

## **PHOTO RELEASE**

(Optional)

I understand and agree that Desert Thunder may take photographs of my child for the sole lawful purpose of publicity, illustration, advertising and web content.

Parent/legal guardian \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*Medical History Survey on back\*\*\*

## MEDICAL HISTORY SURVEY

- ◇ Does participant have any condition that would preclude or limit participation in our programs? If yes, please explain: \_\_\_\_\_ YES / NO
- ◇ Has participant ever been informed that they have asthma? YES / NO  
If so, is it controlled by medication? YES / NO
- ◇ Has participant ever been informed that they might have epilepsy, or ever experienced a seizure? YES / NO
- ◇ Has participant been treated for infectious mononucleosis, viral pneumonia, or another infectious disease during the past twelve months? YES / NO
- ◇ Has participant ever been treated for or informed by a medical doctor that they have a heart problem, a heart murmur, or high blood pressure? YES / NO
- ◇ Has participant ever been told they had hemophilia or other bleeding disorders or currently have easy bleeding or bruising? YES / NO
- ◇ Has participant ever been told that they have a hernia? If so, is it repaired? YES / NO
- ◇ Has participant had any operations in the past two years? If yes, indicate the anatomical site and date:  
\_\_\_\_\_ YES / NO
- ◇ Is participant currently taking prescribed medications? If so, indicate name of drug and indicate why it is prescribed: \_\_\_\_\_ YES / NO
- ◇ Has participant ever been treated for Osgood-Schlatter (knee) Disease? YES / NO
- ◇ Has participant had a fracture during the past two years? If yes, indicate the site of the fracture and the date:  
\_\_\_\_\_ YES / NO
- ◇ Has participant had any joint dislocation during the past two years? If so, please indicate which joint:  
\_\_\_\_\_ YES / NO
- ◇ Does participant ever experience pain in the back? YES / NO  
If yes, indicate frequency by circling an answer:  
SELDOM / OCCASIONALLY / FREQUENTLY / ONLY ON VIGOROUS EXERCISE OR HEAVY LIFTING
- ◇ Is participant allergic to penicillin or any other medications? YES / NO  
If so, please list: \_\_\_\_\_
- ◇ Have there been any disciplinary, emotional, learning disabilities or other concerns which we should be aware of? If so, please explain: \_\_\_\_\_  
\_\_\_\_\_

PARENT / GUARDIAN / STUDENT: All of the above questions have been answered completely and truthfully to the best of our knowledge.

Date \_\_\_\_\_ SIGN \_\_\_\_\_

Date \_\_\_\_\_ SIGN \_\_\_\_\_