SHENDEREY GYMNASTICS CENTRE

Newmarket's #1 Gymnastics Facility!

Phone: 905-895-4194 17075 Leslie Street Unit 3 Newmarket, ON L3Y 8E1

Recreational & Special Needs
Participant Consent & Medical Data Record

Note: If the information is not provided, the applicant will not be permitted to participate in the activity.

NAME OF PARTICIPANT(SURNAME)_____(FIRST NAME)_____

MALE:_____ FEMALE:_____ BIRTHDATE (D/M/Y)_____ AGE:_____

PHONE #:_____ CELL #_____ WORK #_____

ADDRESS:_____ CITY/TOWN_____

POSTAL CODE:_____ NAME OF PARENT/GUARDIAN:_____

EMAIL ADDRESS:_____

HOW DID YOU HEAR ABOUT US?_____

ARE YOU A RETURNING CLIENT? YES _____ NO_____ DISIPLINE:___ARTISTIC

DOES THE PARTICIPANT HAVE ANY PHYSICAL, MENTAL OR MEDICAL CONDITIONS THAT, FOR SAFETY REASONS, SHOULD BE DISCLOSED?

NO_____ YES_____ SPECIFY_____

HAS THE PARTICIPANT EVER HAD AN INJURY OR ACCIDENTREQUIRING MEDICAL ATTENTION?

NO_____ YES_____SPECIFY_____

HAS THE PARTICIPANT EVER HAD SURGERY?

NO_____ YES_____ SPECIFY_____

NAME OF FAMILY DOCTOR_____PHONE#_____

HEALTH CARD # (OPTIONAL) _____

IN CASE OF EMERGENCY INVOLVING THE PARTICIPANT, PLEASE CONTACT THE FOLLOWING INDIVIDUAL IF THE PARENT/GUARDIAN IS NOT AVAILABLE.

NAME_____ **RELATIONSHIP**_____

PHONE #_____ **CELL #**_____

CLASS_____DAY_____TIME_____GO#_____

OTHER PAGE TO FILLED OUT IN THE OFFICE