Summer Training Clinics

7632 Hwy 71 West Austin, TX 78733 512-288-9722 office 512-288-4643 fax
www.neg-usa.com neg-usa@outlook.com

Child's Name: _____Sex: ____Age: ___ D.O.B.: ___/___/___

Child's Name: _____Sex: ____Age: ___ D.O.B.: ___/___/___

Child's Name: _____Sex: ____Age: ___ D.O.B.: ___/___/___

Parent's Name: _____ Parent's Name: _____

Address: _____ City: _____ Zip: _____

Home #: _____ Parent's Cell: _____ Parent's Work: _____
Parent's Cell: _____ Parent's Work: _____

Email: _____

_____ Clinic #1 June 8-11 Gymnastics
_____ Clinic #2 June 15-18 Power Tumbling
_____ Clinic #3 June 22-25 Gymnastics
_____ Clinic #4 July 6-9 Power Tumbling
_____ Clinic #5 July 13-16 Gymnastics
_____ Clinic #6 July 20-23 Power Tumbling
_____ Clinic #7 July 27-30 August 1 Gymnastics
_____ Clinic #8 August 3-6 Power Tumbling

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to the nearest medical facility.
Signature of Parent or Guardian:

_____

Child's Physician: _____ Phone #: _____
Any medications taken or known medical problems:

_____

RELEASE OF LIABILITY

All precautions will be taken to prevent accidents. However, should an accident occur, first aid will be administered and parent or doctor will be notified, if necessary. National Elite Gymnastics and staff cannot be held liable for injuries that occur on gym premises or otherwise in the care of National Elite Gymnastics personnel.
I/We _____ assume all responsibility and waive any claim for compensation for injury incurred by my child while at National Elite Gymnastics and hereby agree to indemnify or hold harmless the gym, its owners, and employees against any and all claims which may arise from an injury to my child while participating in the program. I have read and abide by the guidelines.

Signature of Parent or Guardian: _____ Date: _____/_____/_____

Registration Fee: **$30.00 per child Cash/Check/CC #** _____

Clinic #1 **$160.00** **Cash/Check #** _____
Clinic #2 **$160.00** **Cash/Check #** _____
Clinic #3 **$160.00** **Cash/Check #** _____
Clinic #4 **$160.00** **Cash/Check #** _____
Clinic #5 **$160.00** **Cash/Check #** _____
Clinic #6 **$160.00** **Cash/Check #** _____
Clinic #7 **$160.00** **Cash/Check #** _____
Clinic #8 **$160.00** **Cash/Check #** _____

service charge will be applied for credit card payments