



TEAM REGISTRATION FORM

Athlete Information

Gymnast Name: _____ Level: _____

Phone: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

School: _____ Dismissal Time: _____

Parent Information

Father's Name: _____ Phone: _____

Place of Employment: _____ Cell Phone: _____

Mother's Name: _____ Phone: _____

Place of Employment: _____ Cell Phone: _____

Email Address: _____

Emergency Contact Name: _____ Phone: _____

Insurance Information

Doctor's Name: _____ Phone: _____

Do you have accidental medical insurance if so, who is your provider: _____

Any accidental injury insurance policy provided by FIRST STATE GYMNASTICS is a limited policy and is not intended to cover all medical expenses that may occur due to injury. I have been informed that it is strongly advised that all members of the team need to carry their own medical insurance. Furthermore, I agree not to hold FIRST STATE GYMNASTICS or its staff liable for any injuries that occur as a result of participation.

Parent/ Participant Signature (if over 18) Date: _____