Central Ohio Gymnastics

5369 State Route 37 East, Delaware
740-369-3200
centralohiogym@gmail.com

Summer Camps 2020

Gymnastics June 15th -18th 9am-12pm (hosted by Orange)
Gymnastics July 13th - 16th 9am-12pm (hosted by Berlin)
Gymnastics July 20th - 23rd 9am-12pm (hosted by Olentangy)

CAMPERS NAME: _____

DATE OF BIRTH:_____ AGE:_____

ADDRESS:_____

CITY:_____ZIP:_____

PARENTS:_____

DAY PHONE:_____

CELL:_____

PARENT'S EMAIL:_____

CHECK EACH WEEK YOU WILL BE ATTENDING:

_____ June 15-18 9-12pm ($125)
_____ July 13-16 9-12pm ($125)
_____ July 20-23 9-12pm ($125)

Camps include warm up, stretching, conditioning, vault, bars, beam, floor, tumble trak, trampoline, games, snacks, and more!

Children may come with the purpose of learning a specific skill, practicing many skills, or just to have fun in the gym. All children will leave with new skills and many memories!

Waiver of Liability

The undersigned, on behalf of himself/herself and on behalf of his/her child (the "registrant"), recognizing the possibility of physical injury associated with the following activity: **Gymnastics,** and I as parent/guardian offer the registrant for participation in said activity, assumes and accepts full responsibility for any and all liability claims arising from this activity, and releases, discharges and/or otherwise indemnifies **Central Ohio Gymnastics & Cheer, Central Ohio Gymnastics Center, Central Ohio Trampoline and Tumbling** and all their employees and volunteers from liability for any claim by or, on behalf of the registrant as a result of the registrant's participation in the activity.

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

Consent for Emergency Treatment

In the event that reasonable attempts to contact me at_____(phone) or_____(other parent phone) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr._____(preferred Physician) _____ (phone) or Dr._____(preferred Dentist) _____(phone), or in the event that the designated preferred practitioner is not available, by another licensed physician or dentist: and (2) the transfer of the child to_____ (preferred hospital) or any hospital reasonably accessible. Facts concerning the child's medical history including allergies, medication being taken, and any physical impairment to which a physician should be alerted:

_____

_____.

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

Please make check payable to: C.O.G. / $20.00 Non-Refundable Cancellation Fee
Mail completed registration forms and checks to:

Jen Hedrick
6400 Alum Creek Dr.
Galena, OH 43021