

# Lady Pacer/Lady Baron Gymnastics Camp

Hosted at: Central Ohio Trampoline and Tumbling/COGC  
Home of Your Lady Pacer and Lady Barons Gymnastics Teams  
5369 State Route 37 East, Delaware  
740-369-3200  
jmnast2000@aol.com

## Summer Camp

July 6th - 10th

9am - Noon

CAMPERS NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

PARENTS: \_\_\_\_\_

DAY PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_

PARENT'S EMAIL: \_\_\_\_\_

GYMNASTICS EXPERIENCE?      YES              NO

IF YES, WHAT TYPE? \_\_\_\_\_

Students entering K – 8<sup>th</sup> grade will be given instruction by current Buckeye Valley / Hayes Coaches and athletes. We hope to teach basic skills and fundamentals along with advanced skills for those ready. Also, rules and guidelines will be covered with those going into 7<sup>th</sup> and 8<sup>th</sup> grade to help those athletes feel more prepared for upcoming seasons.

**\$75 per child**

**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 Center, Central Ohio Gymnastics, Central Ohio Trampoline & Tumbling, Delaware City Schools and Athletic Boosters, Buckeye Valley Schools and Athletic Booster**, 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 checks payable to:

**Delaware Athletic Boosters (Memo Line: Gymnastics)**

Mail completed registration forms and checks to:

**Heather Besselman**

**48 Birch Row Dr**

**Delaware, OH 43015**