

DATES OF PRACTICE(S): \_\_\_\_\_



# PRACTICE/CLINIC RELEASE FORM

*EACH PARTICIPANT MUST HAVE THIS FORM FILLED OUT COMPLETELY. COACHES SHOULD PRESENT THESE AT THE TIME OF CLASS/CLINIC/PRACTICE. THIS FORM MAY BE DUPLICATED. NO ONE IS ALLOWED TO PARTICPATE AT ANY FUNCTION AT FLIPS GYMNASTICS CENTER WITHOUT THIS FORM.*

SCHOOL OR CHEER ORGANIZATION NAME \_\_\_\_\_

PARTICIPANTS NAME \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_ TOWN/CITY \_\_\_\_\_

STATE/ZIP \_\_\_\_\_ GRADE \_\_\_\_\_ AGE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ PARENT EMAIL \_\_\_\_\_

### WHERE CAN A PARENT/GUARDIAN BE REACH DURING THE EVENT IN CASE OF INJURY?

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

I, \_\_\_\_\_ (PARENT/GUARDIAN) THE UNDERSIGNED, DO HERBY GRANT PERMISSION FOR MY CHILD, \_\_\_\_\_, TO PARTICPATE IN CLASSES/PRIVATE/CAMP/PRACTICE AT FLIPS GYMNASTICS CENTER. I ACKNOWLEDGE AND UNDERSTAND THE RISKS INVOLVED FOR THE PARTICIPANT, \_\_\_\_\_, IN THESE CLASSES/PRIVATE/CAMPS/PRACTICES AND ASSUME THOSE RISKS, WHICH MAY INCLUDE BUMPS, BRUISES, BROKEN BONES, SICKNESS OR EVEN DEATH. I, \_\_\_\_\_ (PARENT/ GUARDIAN), CONSENT TO THIS PARTICIPATION AND FURTHER CERTIFY THAT I AM ADEQUATELY COVERED BY SCHOOL OR PERSONAL INSURANCE AND AGREE TO HOLD HARMLESS, FLIPS GYMNASTICS CENTER, LLC, THEIR COACHES, GYMNASTS, AND STAFF FOR ANY INJURY, SICKNESS OR DEATH SUSTAINED AS A RESULT OF MY CHILD, \_\_\_\_\_ PARTICIPATING IN CLASSES/PRIVATE/ CAMP/PRACTICE, I UNDERSTAND THE ORGANIZATION OF \_\_\_\_\_ COACHES ARE RESPONSIBLE TO PERFORM FIRST AID MEASURES OF ANY INJURY SUSTAINED WHILE AT FLIPS GYMNASTICS CENTER.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARTICIPANT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

### ALLERGY/INJURY'S or PAST INJURY'S/MEDICATIONS BEING TAKEN, ETC

\_\_\_\_\_  
\_\_\_\_\_

WHICH HOSPITAL WOULD YOU LIKE YOUR CHILD TRANSPORTED TO IN THE EVENT OF A MAJOR EMERGENCY \_\_\_\_\_.