



# 2018 SUMMER EVENING CLASSES REGISTRATION FORM

Please drop off form or email to academysportfitness@gmail.com

## **Participant**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: DD \_\_\_\_\_ MM \_\_\_\_\_ YR \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M    F

Special Needs: \_\_\_\_\_ Medication/Allergies: \_\_\_\_\_

OHIP # \_\_\_\_\_

## **Parent/Guardian**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

I hereby consent to Academy of Sport and Fitness Inc. using the email address/es I have specified on this application, to be in compliance with the Canadian Anti-Spam Legislation (CASL).

## **Program requested for Summer 2018**

Please check off (✓) the desired class(es)

| <b>Class</b>            | <b>Tuesday</b> | <b>Wednesday</b> | <b>Thursday</b> | <b>Total Cost<br/>(for office use)</b> |
|-------------------------|----------------|------------------|-----------------|--|
| <b>Parent &amp; Tot</b> |                |                  |                 |  |
| <b>1 Hour Kinder</b>    |                |                  |                 |  |
| <b>1.5 Hours Rec.</b>   |                |                  |                 |  |
| <b>2 Hours Rec.</b>     |                |                  |                 |  |
| <b>Acro (Wednesday)</b> |                |                  |                 |  |

### **Waiver must be signed in order for your application to be processed.**

In consideration of the acceptance of my application and the permission to participate in a program sponsored by the Academy of Sport and Fitness Inc. I hereby waive and forever discharge the Academy of Sport and Fitness Inc. from all claims, damages, costs, and expenses in respect to injury or damage to my person or property, however caused which may result from my participation in the program. I hereby give permission for emergency medical treatment to be administered to my son/daughter, as may be determined reasonable by a medical attendant. It is understood that whenever reasonably possible, relatives will be contacted and informed of the problem, diagnosis, treatment and anticipated medical results.

### **No Refunds (Program Credit Only)**

A written request for a refund must be received in the office no later than one week after attending the first class. A \$25 cancellation fee will apply.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_