CCG Survivor 3-day Camp

REGISTRATION FORM

Email: camp@iflipforccg.com

1. **Child's Name:** _____

   Age: _____ Date of Birth: _____ **M / NM**

2. **Child's Name:** _____

   Age: _____ Date of Birth: _____ **M / NM**

Parent's Name: _____

Email: _____

Address: _____

Home Phone: _____ Cell: _____

Notes: _____

I release Central Coast Gymnastics Training Center and its coaching staff from any liability incurred as a direct result of my child's participation in this "Thanksgiving Survivor Camp." I also authorize any medical personnel as agents for the undersigned to consent to any diagnostic procedure (including X-Rays), to the administration of any medical or surgical treatment, or to any hospital care when any or all rendered under the general supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act. THE AUTHORIZATION IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS, TREATMENT, OR MEDICAL CARE BEING REQUIRED, AND PURSUANT TO THE PROVISIONS OF SECTION 258 OF THE CALIFORNIA CIVIL CODE. A 50% non-refundable deposit due at time of registration. **Refund requests must be in writing one week prior to camp start date.** If after deadline date, 50% account credit will only be given, no exceptions. A Late fee of $10 will be applied if balance is not paid by end of first day.

Parent Signature: _____

❑EB ❑Regular **Pricing**:

Dates: **Days (FD/HD) #kids:** **Fees:**

Nov 20-22 _____ _____

B/A Care: ___ hrs X ___ kids X $8/hr = _____

Days/Times B/A Care:_____ **Total due:** _____

B/A Care space limited Deposit pd: $_____

Check #: _____ CC type: _____ Cash ☐

Total Balance Due (1st day): _____

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