



CAPITOL CITY GYMNASTICS

Return w/payment to:
3518 Rohr Rd. Groveport, OH 43125
614-409-7655

ADULT REGISTRATION FORM

TODAYS DATE: _____

Student's Name _____ Birthdate: _____ Age: _____

Address: _____

City: _____ State/Zip: _____

Second Address(if necessary): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Emergency Contact Name: _____ Relation to Family: _____

Emergency Phone: _____

Medical Information

Preferred Hospital: _____

Preferred Physician: _____ Phone: _____

Preferred Dentist: _____ Phone: _____

Current or Past Medical History: _____

Medical and Liability Release: *I hereby consent and grant authority to the staff at Capitol City Gymnastics to make any medical judgement concerning medical attention in the event of an emergency or accident. Understanding the possibility of an injury in any athletic or physical endeavors, I hold Capitol City Gymnastics and its staff harmless for any and all injuries arising out of taking part in any classes, workouts, exhibitions and competitions at Capitol City Gymnastics, in route or away.*

Signature: _____ Date Signed: _____