2019 NEAG Summer Program Registration

PLEASE FILL OUT BOTH PAGES OF THIS FORM. PLEASE PRINT CLEARLY.

**Only one form per camper*

Camper Name:

Sex: M / F	Age:	Birthdate:
Address:		Apt:
City:	State:	Zip:

Parent/Guardian Name #1:	**Parent / Guardian Name #2**
Address:	Address:
City, State, Zip:	City, State, Zip:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Email:	Email:

Emergency Contact #1:	**Emergency Contact #2:**
Relationship to Child:	Relationship to Child:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:

Has your child ever been enrolled in a program at NEAG? _____YES _____NO

Pick-Up Authorization

Please list up to three people who are authorized to pick up your child from NEAG. Individuals listed above are automatically authorized, unless specifically listed as "Non-Authorized" below.

Your child will only be released to an authorized person with a photo ID.

1._____ 2._____3._____

Non-Authorized Pick-Up

1._____ 2._____ 3._____

In the signing of this registration form, parents/guardians accept the following statements:

I/We the parents/guardians of (Participant's name)_____give my/our approval for his/her participation in the programs at New England Academy of Gymnastics. *I/We assume all risks and hazards incidental to the conduct of the programs. *I/We, the undersigned, being of legal age and acting guardian of the participant, releases and holds harmless New England Academy of Gymnastics or any and all representatives of New England Academy of Gymnastics from any and all responsibility of injury acquired by the participant, visiting children, and parent/guardian while on the premises, or at sites associated with participation in the programs. *I/We understand that our child should never be dropped off or picked up outside or left for any extended time without parent/guardian supervision. *I/We understand that New England Academy of Gymnastics reserves the right to dismiss any student whose conduct is detrimental to the overall good of the program. *I/We understand that if an emergency arises which should require immediate medical attention, and we, as the parents/guardians cannot be contacted, the staff of New England Academy of Gymnastics are authorized to take whatever steps necessary to protect the health of the participant.

Parent/Guardian Signature_____ Date_____

New England Academy of Gymnastics
894 Boston Post Road East * Marlborough, MA. 01752
Phone: 508-460-6324 * Fax: 508-460-6320
www.newenglandgymnastics.com

2019 NEAG SUMMER PROGRAM REGISTRATION

STUDENT NAME_____

	Week 1 6/17-6/21	Week 2 6/24-6/28	Week 3 7/8-7/12	Week 4 7/15-7/19	Week 5 7/22-7/26	Week 6 7/29-8/2	Week 7 8/5-8/9	Week 8 8/12-8/16	Week 9 8/19/8/23	TOTAL
Full Day Programs: Ages 5-12				***Please note that camp will be closed the week of July 2nd-6th**						
Gym & Swim Camp $360/Week	NOT OFFERED	NOT OFFERED		NOT OFFERED		NOT OFFERED		NOT OFFERED		
Flip & Trip Camp $360/Week	NOT OFFERED		NOT OFFERED		NOT OFFERED		NOT OFFERED		NOT OFFERED	
Extended Day										
3:00-4:00pm $50/week										
3:00-5:00pm $100/week										

Mini-Camp: Ages 3-4 **must be potty trained*										
	6/17/19	**6/18/19**	**6/19/19**	**6/20/19**	**6/21/19**	**6/24/19**	**6/25/19**	**6/26/19**	**6/27/19**	**6/28/19**
9:00-12:00 $45/day										

**No deposit on Mini-Camp. Tuition due at time of registration.*

TOTAL PROGRAM TUTION	
TOTAL DEPOSIT DUE AT TIME OF REGISTRATION ($50 PER SESSION)	
TOTAL DISCOUNTS	
REMAINING BALANCE DUE BY JUNE 1ST	

METHOD OF PAYMENT: _____Check enclosed _____Credit Card

Total Payment Enclosed: $

Name on card:_____

Card number:_____ Exp Date:_____

Signature:_____

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2019 NEAG Summer Program
Health History and Examination Form

THIS PAGE MUST BE COMPLETED AND SIGNED BY A PARENT/GUARDIAN. IN ACCORDANCE WITH THE COMMONWEALTH OF MASSACHUSETTS LAW CHILDREN MUST HAVE HAD A PHYSICAL WITHIN 24 MONTHS PRIOR TO ATTENDING CAMP. PLEASE ATTACH A COPY OF YOUR CHILD'S MOST RECENT PHYSICAL OR USE THE FORM PROVIDED.

CHILD NAME

Birthdate_____ Sex_____ Age_____
Home Address_____
City_____ State_____ Zip_____

Parent/Guardian

Home Address_____
City_____ State_____ Zip_____
Home Phone_____ Cell Phone_____
Work Phone

Emergency Contact #1)_____ Relationship_____ Phone_____
Emergency Contact #2)_____ Relationship_____ Phone_____

Medical History

Are you, or have you ever been treated for any of the following:

Yes	No	Condition	Explain
		Frequent Ear Infections	
		Heart Defect / Disease	
		Seizures	
		Diabetes	
		Bleeding Disorders	
		Chicken Pox	
		Asthma	
		Frequent Bloody Nose	
		Surgery	
		Poison Ivy	
		Insect Stings	
		Broken Bone	
		Sprain	

Name of child's physician_____ Phone_____
Name of child's dentist/orthodontist_____ Phone_____

Medical Insurance Information

Subscriber Name		SSN (optional)	
Carrier Name		Carrier Address	
Group Name		Group Number	

This information is correct and complete to the best of my knowledge. My child _____has my permission in all NEAG activities except as noted by me, and/or the examining physician. I hereby give permission to NEAG to provide routine health care, administer pre-prescribed medications, and seek emergency medical treatment including x-rays, and routine tests. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person named above.

Signature_____ Date_____

THIS PAGE IS TO BE FILLED OUT BY A LICENSED PHYSICIAN OR YOU MAY ATTACH THE PHYSICIANS OWN FORM

Children's Name_____

Please record all dates (month and year) of immunizations and most recent booster doses

Date of last physical exam_____

Must be within 24 months of child's attendance at NEAG

Height_____ Weight_____Pulse_____Blood Preassure_____

VACCINES	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DPT Diptheria, Pertussis, Tetanus					
TD Tetanus, Diptheria					
Tetanus					
Polio					
MMR Measles, Mumps, Rubella					
Measles					
Chicken Pox					
Tuberculin Test					
HB Haemophilus, Influenza					
Hepatitis B					
Other					

Is the applicant currently under the care of a physician? If yes, why._____

_____

_____

Allergy History

This child has allergies……. ☐ YES ☐ NO ……. If yes, please document below.

ALLERGEN	Typical Reaction	Treatment Plan

Current Medications_____

*If child will be taking prescription medication during the day, it must be in the original prescription container with the current correct dosage on it. If dosage is different than listed on the prescription container, the prescribing physician must provide documentation

Recommendations and/or restrictions while at NEAG_____

_____

In my opinion, the above child may participate in an active recreational program with the noted restrictions abov

Licensed Physicians Signature_____Date_____

Address____Office Phone________________________________

strictions above.

2019 NEAG Summer Programming

MEDICATION AUTHORIZATION FORM

GYMNAST NAME_____ DOB_____

All medications including perscription, over-the-counter medications, allergy injections, food supplements, and vitamins must have a Medication Authorization Form on file to be administered at NEAG. Any medications brought to NEAG must be kept in the medications box, kept by the program director. This box travels with the program at all times. No child may carry their own medications. All prescription and over the counter medication, must be received in their original container with label bearing a current date, child's name, drug name, and the prescribing licensed providers name, or over the counter packaging. Medications brought to NEAG must come with the child at the beginning of each day, and leave with the child upon pickup the same day. NEAG will not keep medications on site overnight.

As the parent of the above named child, I hereby authorize New England Academy of Gymnastics to administer my child the medications as indicated below. If there is a change in prescription, the child's health care provider must provide documentation.

Parent / Guardian Signature _____

Medication_____
Route of Administration_____ Dosage_____
Frequency_____ Time of Administration_____
Specific directions or information for administration_____
Side effects, or possible adverse reactions to be observed_____
_____

Medication_____
Route of Administration_____ Dosage_____
Frequency_____ Time of Administration_____
Specific directions or information for administration_____
Side effects, or possible adverse reactions to be observed_____
_____

Medication_____
Route of Administration_____ Dosage_____
Frequency_____ Time of Administration_____
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_____

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