

# BROWN'S GYMNASTICS

## 2006 "All Sports Day Camp"

**MAY 25 - JULY 28**

### FULL or HALF DAY PROGRAMS

- ♥ *Girls and Boys Ages 3 to 12 Years*
- ♥ *Drop off between 7:30-9:00 A.M.*
- ♥ *Pick up by 12:00 Noon or 5:30 P.M.*
- ♥ *Bring your own lunch, snacks & drinks*
- ♥ *Daily Gymnastics Instruction Included*
- ♥ *Field Trips (additional fee)*
- ♥ *10 % off each additional child*

- Gymnastics Daily*
- Bowling*
- Zoo*
- Movies*
- Arts & Crafts*
- Pottery*
- Swimming*

\$140—5 FULL DAYS	\$105—5 HALF DAYS
\$ 90—3 FULL DAYS	\$ 35—1 FULL DAY
\$30— 1 HALF DAY	

CIRCLE DAYS:    M    T    W    TH    F

CHILD'S NAME \_\_\_\_\_ AGE \_\_\_\_\_ DOB \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_ AGE \_\_\_\_\_ DOB \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

PARENTS NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_

ADDITIONAL EMERGENCY NUMBER \_\_\_\_\_ CELL PHONE \_\_\_\_\_

WORK NUMBER (Mother) \_\_\_\_\_ (Father) \_\_\_\_\_

CAMP PROGRAM DESIRED \_\_\_\_\_ E-MAIL \_\_\_\_\_

I hereby authorize the staff of Brown's Gymnastics Camp to act for me according to their best judgment in any emergency requiring medical attention & hereby waive & release the camp staff and Brown's Gymnastics from any and all liability for any injuries and illness incurred while at the camp. I understand that participation in gymnastics and various sports activities involves motion and as such carries with it the risk of injury. The camp is not responsible for personal items that are lost, stolen, or damaged. All medical expenses incurred will be the responsibility of the camper's family. In lieu of medical certificate signed by a medical doctor, I have not knowledge of any physical or mental impairment that would be affected by the named camper's participation in the camp program. I also understand the Camp retains the right to use any photographs, videotapes, motion picture recordings, or any other record of this event for publicity, advertising, or any legitimate purpose.

SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_ PAYMENT METHOD \_\_\_\_\_

CIRCLE WEEKS YOU WANT TO ATTEND

- Week 1—MAY 25    Week 2—MAY 30    Week 3— JUNE 5    Week 4— JUNE 12    Week 5—JUNE 19  
 Week 6—JUNE 26    Week 7—JULY 3    Week 8—JULY 10    Week 9—JULY 17    Week 10—JULY 24

CHECK LOCATION:    \_\_\_\_\_ Altamonte Springs Gym (407) 869-8744    \_\_\_\_\_ Sanford/Lake Mary Gym (407) 302-2044  
**VISA AND MASTER CARD ACCEPTED**

REGISTRATION FEE : \$20.00 1st Child & \$15.00 2nd Child (If not currently enrolled in Brown's Gymnastics)  
 (SEE OTHER SIDE)



**PLEASE COMPLETE ENTIRELY AND PRINT LEGIBLY**

Mother's Employer: \_\_\_\_\_

Father's Employer: \_\_\_\_\_

Persons authorized to pick up: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Authorization Code for Pickup (Private Code) \_\_\_\_\_

(example—pet name, favorite character, number)

Persons to be contacted in Case of Emergency:

(Be sure to include someone who will usually know your whereabouts)

Name \_\_\_\_\_

Address \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency Hospital Preference \_\_\_\_\_

Medical Conditions \_\_\_\_\_ Allergies \_\_\_\_\_

Special Instructions \_\_\_\_\_

\_\_\_\_\_

**Please attach a copy of your medical insurance card to this form. Failure to supply insurance information may cause unnecessary delay in receiving emergency care.**