

S.O.A.R

(Students of All Abilities Respected)

2009 – 2010 Registration Form

Form must be filled out in its entirety with all signatures.

Annual membership fee of \$25/individual or \$40/family must be paid if not current.

I. Child PLEASE PRINT

1 st Child's Name (First/M.I./Last):	Circle: Male Female
Date of Birth:	Nickname:
2 nd Child's Name (First/M.I./Last):	Circle: Male Female
Date of Birth:	Nickname:
State Date: Grade:	School Name: Grade:

II. Parent/Guardian

Name:	Relationship to Child:	
Address:	City:	State/Zip Code:
Home Phone: ()	Mom's Cell Phone: ()	Dad's Cell Phone: ()
Mom's Employer:	Mom's Work Phone: ()	E-Mail Address:
Dad's Employer:	Dad's Work Phone: ()	E-Mail Address:

III. Emergency Contact (other than Parent/Guardian)

In case of an emergency and guardians cannot be reached, the following adults should be contacted: (Required to be local; Parents must list a minimum of two individuals). These individuals will be authorized to pickup unless otherwise indicated.		
Name:	Relationship:	
Home Phone:	Cell Phone:	Work Phone:
Name:	Address (Required):	City/State/Zip:
Home Phone:	Cell Phone:	Work Phone:

IV. Additional Authorized Pickups

Unless otherwise authorized in writing, no one but the Parent/Guardian/Emergency Contacts may pickup children from TNT. List below other adults authorized for this purpose. A photo ID may be required at time of pickup. **(Note: Additions or deletions may be made to this at any-time by contacting TNT in writing.)**

Name:	Relationship:
Name:	Relationship:

V. Medical Information (Required)

Name of Physician:	Phone:
Address of Physician:	City/State/Zip:
Hospital Preference:	Phone:
Clinic:	Phone:

VI. Medical Conditions

Please check any that apply for your child.	
Attention Deficit Disorder (ADD)	Hyperactivity Disorder (ADHD)
Mild to Moderate Mental Impairment (MMMI)	Moderate to Severe Mental Impairment (MSMI)
Attention Deficit	Early Childhood Special Education (ECSE)
Allergies: (Please list)	Food Allergies: (Please List)
Emotional/Behavioral Disturbed (ECSE)	Depression Disorder
Asthma, RAD	Visual Impairment
Eczema/Dermatitis	Speech Impairment
Seizure	Hearing Impairment
Specific Learning Disability	Physical Disability
Developmentally Delayed	Other – Please specify:
Are there any medications that your child takes on a regular basis? YES NO	
If yes, please list:	

VII. 2009-2010 “School Year” Tuition Rates

S.O.A.R. After School Program Rates Per Child; Per Week Payment is due by 6:00PM on the first day of the week my child attends SOAR	
Registration Fee:	\$25.00 per child
Full-Time: 4/5 days a week; pick up time 6:00PM	\$50.00 per week; per child
Part-Time: 1-3 days a week; pick up time 6:00PM	\$30.00 per week; per child
Which Days Will Your Child Will Attend SOAR?	
Circle Days : Monday Tuesday Wednesday Thursday Friday OR Full-Time (M-F)	
It is the policy of TNT that a child not be released to any individual who is not named on this registration form as a parent/guardian or indicated as an emergency contact or authorized pick up. Verbal permission by the parent is not permitted. Any change must be made to the front office in writing by the parent/guardian. A photo ID may be required at time of pickup. SOAR services close at 6:00 PM daily. When a child is not picked up by 6:00 PM there will be an additional \$10.00 late charge for up to every 15 minutes after 6:00 PM.	

Parent Consent:

1. I understand that I may visit my child at TNT at any time.
2. I understand that corporal punishment and abuse of any kind will not be allowed at TNT.
3. I understand that TNT MUST report any abuse or neglect suspected or observed to the proper authorities.
4. I understand that if my child has special needs I must schedule a meeting with the Kid’s Fitness Director prior to attending TNT.
5. I understand that I must report any changes regarding employment status, address, phone numbers, or other relevant information to TNT in a timely manner.
6. I understand I must supply my child with sunscreen and insect repellent.
7. I give permission for TNT to transport my child from the their school.
8. I give permission for TNT staff to assist in applying sunscreen and/or insect repellent to my child.
9. I give permission for TNT staff to use antiseptic wipes, antibiotic cream, hydrocortisone cream, & first aid in the event my child is injured.

ASSUMPTION OF RISK, WAIVER OF LIABILITY, AND MEDICAL AUTHORIZATION

In consideration for allowing my child(ren) to use these facilities, I, on my behalf of my child(ren) and as legal parent/guardian, I recognize what potentially severe injuries, including permanent paralysis or death can occur in sports or activities involving height or motion, including but not limited to gymnastics, tumbling & trampoline, birthday parties, special events & activities including inflatables, camps, parent participant activities and any and all other programs offered at TNT Kid’s Fitness & Gymnastics Academy. Being fully aware of these dangers, I voluntarily consent to the aforementioned person(s) participating in any and all TNT Kid’s Fitness & Gymnastics Academy programs and activities and I ACCEPT ALL RISKS associated with that participation. By your attendance in class or events at TNT, you are granting your permission for you and your child to be filmed, videotaped, audio taped, or photographed by a means and are granting full use of your likeness, voice, and words without compensation. In the event of an emergency I would like my below mentioned child(ren) to be taken to a hospital for medical treatment and I hold TNT Kid’s Fitness & Gymnastics Academy and its representatives harmless in their execution of this action. Additionally, I hereby agree to individually provide for all possible future medical expenses which may be incurred by my child as a result of any injury sustained while participating at or for TNT Kid’s Fitness & Gymnastics Academy. **I have read and understood this ASSUMPTION OF RISK, WAIVER OF LIABILITY & MEDICAL AUTHORIZATION.**

I have read and agree to the policies and procedures listed above.	
Parent Signature:	Date: