

Child's Last Name _____

Child's First Name _____

EMERGENCY INFORMATION RECORD
C.S. GYMNASTICS, INC.

In case of an emergency, if you cannot reach me (parent/guardian), please contact:

Neighbor/friend _____ Phone# (____)-____-_____

Parent _____ Cell Phone# (____)-____-_____

Family Doctor _____

Address of Doctor _____

Phone# of Doctor (____)-____-_____

Preferred Hospital _____

Learning/Physically challenged Yes No

If Yes, describe: _____

If child has ADD/ADHD, will he/she be medicated during class? Yes No

Check and describe if applicable:

Allergies Yes No _____

Required Medications Yes No _____

Previous Major Injuries Yes No _____

Chronic/Recurring Injuries Yes No _____

I verify the above information is true and accurate. In the event of an emergency, I understand that I will be notified as soon as possible.

I grant permission as parent/guardian for my child to be taken to the above stated preferred hospital.

Date ___/___/_____ Parent/Guardian's Signature _____