Athlete Enrollment Form

Today's Date : ______ / ______ / ______

--- For office use only ---

Trial Date: ______/______/______

Class: ________________________________

Day(s) : M / T / W / TH / F / Sa Time : ___________

Start Date: ______ / ______ / ______

Tuition: $__________ Prorate: $___________

Registration: $________ Total due : $___________

Follow-up After Trial:

Athlete Information :

Name: (First) ___________________ (Middle) ___________________ (Last) ___________________

Birthday: ______ / ______ / ______ M ___ F ___ Age: ___ Home phone: (____)___________

Address: _________________________________ City: _______________ ST : ___ Zip: ______

School: ____ Grade : _____

Parent / Guardian Contact Information :

Name : ______________________________ Relationship :___________ Cell : (____)___________

Place of work : ____ Phone : (____)___________

Name : ______________________________ Relationship :___________ Cell : (____)___________

Place of work : ____ Phone : (____)___________

E-mail : ____

Emergency Contact (In case parents can't be reached):

Name ______________________________________ Phone : (____)___________

Athlete Medical Information :

Please list any known allergies/ medications/ medical conditions that the staff should be aware of:

____

Insurance Co. : ____ Policy # : __________________

Family Doctor : ______________________ City : _______________ Phone : (____)___________

How did you hear about Rigert Elite Gymnastics? ____

831 NW Corporate Drive, Troutdale, Oregon 97060
503-912-0325

Rigertelitegymnastics.com
RigertEliteGymnastics@gmail.com

Participant's Name: ____

1. Has a doctor ever said you have a heart condition and recommended only medically supervised physical activity? ……………………………………………………..……☐ Yes ☐No

2. Do you have chest pain brought on by physical activity? …………………………………………………☐ Yes ☐No

3. Do you tend to lose consciousness or fall over as a result of dizziness? …………………………………☐ Yes ☐No

4. Has a doctor ever recommended medication for your blood pressure, heart condition, or other disorder that could influence your ability to perform gymnastics? ….……………………...☐ Yes ☐No

5. Do you have a bone or joint problem that could be aggravated by gymnastics? ………………………….☐ Yes ☐No

6. Have you developed chest pain within the past month? ……………………………………………………☐ Yes ☐No

7. Are you aware, through your own experience or a doctor's advice, of any other physical reason against your exercising without medical supervision? ……………….…………..☐ Yes ☐No

If so please explain: ____

____

____

Additional Questions:

8. Have you ever had a neck injury, head injury or concussion? ……………………………………………….☐ Yes ☐No

9. Are you currently or recently recovering from a significant illness (flu, mononucleosis, pneumonia, etc.)? ..☐ Yes ☐No

10. Do you have a convulsive disorder? …………………………………………………………………...☐ Yes ☐No

11. Do you have asthma? ………………………………………………………………………………..☐ Yes ☐No

12 . Do you have an infectious skin disorder?.. ....☐ Yes ☐No

13. Do you have a history of a liver disorder, spleen disorder, kidney disorder or detached retina?....................☐ Yes ☐No

Parent Signature: ____ Date: _______________

Athlete (18 or older) Signature: ____ Date: ________________