



CAPITAL DISTRICT YMCA Circle of Champs Program Enrollment Form

CHILD'S INFORMATION

Name _____ Birthdate ___/___/___ Age ____

Gender (circle one): M/F/Other School _____ Grade in September _____

Address _____

City _____ State _____ Zip _____

How did you hear about Circle of Champs?

Please let us know your preferred method of communication:

Facebook (private Champs group) Email Phone

PARENT & GUARDIAN INFORMATION

Name _____ Name _____

Address _____ Address _____

City, State, Zip Code _____ City, State, Zip Code _____

Home Telephone _____ Home Telephone _____

Work Telephone _____ Work Telephone _____

Email _____ Email _____

Siblings & Ages _____

PHYSICIAN AND MEDICAL INFORMATION

Physician Name _____

Hospital / Treatment Facility _____

Office Telephone _____ Fax _____

Address _____

Complete Street Address City State Zip Code

Emergency Contact _____ Phone _____ Relationship _____

Authorized Pickup *: Name _____ Relation _____

Name _____ Relation _____

* For the safety of your child, the person authorized for pick up needs to have at least one form of identification when picking up your child.

AGREEMENT

I hereby certify that my child is capable of safe participation in YMCA Circle of Champs activities. I assume all risk(s) and hazards incidental to the conduct of this program and for transportation to and from the program. I hereby authorize the YMCA to obtain medical treatment for my child in the event that I or my child's emergency contact cannot be reached. I give permission to the YMCA to take video and/or photographs of myself and/or my children for the purpose of promoting YMCA programs: Yes No

Signature Parent or Guardian

Date