

Office Use Only

Term: 1 2 3 4 5 6 Year: _____

Gym. Aust. Mem No. _____

Insurance Registration MYOB Jackrabbit

Membership Pack Issued: ___/___/___



REGISTRATION FORM 2011

Registering Participants Personal Information

Surname: _____ Given Names: _____

Address: _____ Post Code: _____

Email Address: _____ Telephone: _____ (home)

All AGDA Correspondence is done via email. If you do not have an email address please make sure you do weekly checks at Reception for Newsflashes and correspondence.

Date of Birth: ___/___/___ Gender: M/F School/Day care Attending: _____

Date of Registration: ___/___/___ Previous or New Member (Please circle)

Participant's Family Information

Contact No 1:

Name: _____ Mother/Father/Guardian/Grandparent/Spouse/Other

Home Ph: _____ Work Ph: _____ Mobile: _____

Contact No 2:

Name: _____ Mother/Father/Guardian/Grandparent/Spouse/Other

Home Ph: _____ Work Ph: _____ Mobile: _____

Sibling Members at AGDA:

Name _____ Date of Birth ___/___/___ Sister/Brother/Other (circle)

Name _____ Date of Birth ___/___/___ Sister/Brother/Other (circle)

Name _____ Date of Birth ___/___/___ Sister/Brother/Other (circle)

EMERGENCY CONTACT: (IN CASE OF EMERGENCY AND THE ABOVE CANNOT BE CONTACTED)

Name: _____ Mother/Father/Guardian/Grandparent/Spouse/Other

Home Ph: _____ Work Ph: _____ Mobile: _____

Program Details

Class Type: (please circle below) **Class Day:** _____ **Class Time:** _____

GYMNASTICS:

Kindergym Krew - Kangaroos Koalas Wombats Platypus

Progression to Purpose - Monkeys Bunny's Possums Seals Award 5/6 Award 7/8 Award 9/10

WG Recreational Levels – 1 2 3 4 5

MG Recreational Levels – 1 2 3 4 5

WG Competitive – Jnr P/C, P/C, RFTS Aqua / Red / Blue, RS Aqua / Red / Blue, SS Aqua / Red / Blue

MG Competitive – Jnr P/C, P/C, RFTS Aqua / Red / Blue, RS Aqua / Red / Blue, SS Aqua / Red / Blue

TRAMPOLINING:

Recreational Trampoline – Award 1 2 3 4 5 6 7 8 9 10, ART 11 12 13 14 15

TRP Competitive - RFTS Aqua / Red / Blue, RS Aqua / Red / Blue, SS Aqua / Red / Blue

DANCE:

Dance for Fun and Fitness

OTHER PROGRAM: _____

Note: Set days and times apply to Competitive classes. Gymnastics Competitive Teams are by invitation only.

Please read our information packs and website for more information on Early Bird Registration and how to book in from one term to the next, Fun Comps and AGDA Fundraising Committee and what the committee can do for your children.

MEDICAL FORM

A formalised procedure is in place should a gymnast/dancer be injured whilst training or competing. All injuries are recorded in an 'incident report' or 'accident report' and are reported to parents. It is imperative that at each lesson we be advised of all conditions that may affect the participant whilst training now and in the future.

DECLARATION

I/We being the parent/legal guardian/s of the participant named in this form declare the information to be complete and correct to the best of our knowledge and acknowledge this and the granting of our permission for matters detailed herein by our signatures appearing below. I/We accept responsibility in having to provide updated information in writing to amend this form if required at a later stage.

OR

I, being the participant of legal age, named in this form declare the information to be complete and correct to the best of my knowledge and acknowledge this and the granting of my permission for matters detailed herein by my signature appearing below. I/We accept responsibility in having to provide updated information in writing to amend this form if required at a later stage.

Signature of Parents/Legal Guardians or Participant (over 18 yrs).

I/We understand that Gymsport and Dance activities involve motion, rotation and height in a unique environment and as such carries with it a reasonable assumption of risk.

Signed: _____ Date: ___ / ___ / _____

Please Print Name: _____

Participant Medical Information

Participant's Name: _____

Is the participant on any medication of which we should be aware? Yes No

If Yes, please list _____

In case of an accident or illness, if contact is not possible, please list the Doctor or Hospital that you would prefer us to advise (MAY NOT necessarily be the one that treats your child).

Doctor: _____

Address: _____

Telephone: _____

OR

Hospital: _____

MEDICAL HISTORY

Does the participant have, or have ever had, any of the following conditions? If so, please state if they still have the condition now or recurring symptoms.

INJURED INJURY

(Please circle if applicable)

YES / NO ----- Spinal	Recurring YES	YES / NO ----- Neck	Recurring YES
YES / NO ----- Shoulder	Recurring YES	YES / NO ----- Elbow	Recurring YES
YES / NO ----- Arm/Wrist/Hand	Recurring YES	YES / NO ----- Rib Cage	Recurring YES
YES / NO ----- Hip	Recurring YES	YES / NO ----- Thigh	Recurring YES
YES / NO ----- Knee	Recurring YES	YES / NO ----- Ankle	Recurring YES
YES / NO ----- Foot	Recurring YES	YES / NO ----- Muscle Strains	Recurring YES
YES / NO ----- Neck	Recurring YES	YES / NO ----- Concussion	Recurring YES
YES / NO ----- Skull Fracture	Recurring YES	YES / NO ----- Lower Leg/Shin Splints	Recurring YES
YES / NO ----- Other HEAD INJURIES (please list)			

Does the participant have any false teeth or a bridge? YES / NO

Has the participant been advised to restrict activity in the last 5 years? YES / NO

If YES, please elaborate _____

Does the participant have, or has ever had, any of the following conditions?

HAD ILLNESS or ILLNESS RECURRING (Please circle all)

YES / NO -----	Headaches	Recurring YES	YES / NO -----	Fainting spells/dizziness/weakness	Recurring YES
YES / NO -----	Epilepsy/convulsion	Recurring YES	YES / NO -----	Weak or ill in hot weather	Recurring YES
YES / NO -----	Numbness/tingling	Recurring YES	YES / NO -----	Nose bleeds	Recurring YES
YES / NO -----	Hearing problems	Recurring YES	YES / NO -----	Tuberculosis	Recurring YES
YES / NO -----	Pneumonia	Recurring YES	YES / NO -----	Rheumatic Fever	Recurring YES
YES / NO -----	High Blood Pressure	Recurring YES	YES / NO -----	Heart Murmur	Recurring YES
YES / NO -----	Arthritis	Recurring YES	YES / NO -----	Diabetes	Recurring YES
YES / NO -----	Anemia	Recurring YES	YES / NO -----	Abnormal bleeding tendencies	Recurring YES
YES / NO -----	Thyroid Disorders	Recurring YES	YES / NO -----	Skin Disorders	Recurring YES
YES / NO -----	Any allergies	Recurring YES	YES / NO -----	Asthma	Recurring YES
YES / NO -----	Hepatitis	Recurring YES	YES / NO -----	Loss of, or serious impairment of an organ (eg kidney, eye, lung)	Recurring YES

If you answered YES to any of the above, please elaborate: _____

Please provide details of any medical, physical or intellectual condition that may have a bearing on the participant's ability, safety or behaviour in class: _____

Anything else not mentioned that we should be aware of? _____

THANK YOU FOR PROVIDING THIS INFORMATION WHICH WILL BE HELD IN STRICT CONFIDENCE.

Payment Details

Please Tick Box:

- Pay-In-Advance: Number of Terms _____ @ \$ _____ + Membership Fee \$60.00 = \$ _____
- Pay by the term: Term Fee \$ _____ + Membership Fee \$60.00 = \$ _____
- Payment Plan (please see Reception for Terms and Conditions), agreement attached.
- Credit Card on File (please tick if you want your Credit Card kept on file for automatic tuition charging for each term until you notify us otherwise): Term Fee \$ _____ + Membership Fee \$60.00 = \$ _____

Payment Options:

- Cash
- Cheque (made payable to AGDA, pay to Reception of mail to PO Box 471, Morayfield, Qld, 4506)
- EFTPOS
- Electronic Transfer to AGDA. BSB 484 799 Account No 6020 34050 (on transfer please put your child's name & payment reason and fax or deliver this form to our office).
- Credit Card. Please debit \$ _____ + 2% service charge from my credit card.
Type of card: MasterCard Visa Bankcard Cardholders Name: _____
Card Number _____ Expiry Date __ / __
Cardholders Signature: _____