Fit Club at the YMCA
Dr.Riba's Health Club

Insurance: _________ Date Of Birth _____________ Age:_____ Have you attended Fit Club before? Yes No

Do you have any siblings that are 0-5 years old? Yes No Are you a patient at Dr. Riba's Health Clinic? Yes No

Student Information

____

Last Name First MI

____

Street Address

____

City ZIP

Parent / Legal Guardian Information

____

Last Name First Relationship

____

Street Address

____

City ZIP

____

Home Phone Work Phone Cell Phone

Emergency Contact Information

____

Last Name First Relationship

____

Home Phone Work Phone Cell Phone

I UNDERSTAND THAT IF MY CHILD IS PICKED UP LATE FROM THE PROGRAM I WILL HAVE TO PAY A $20 RE-ENTRY FEE ON THE FIRST VIOLATION, AFTER THE SECOND MY CHILD WILL BE EXPELLED FROM THE PROGRAM UNTIL THE NEXT SESSION HE/SHE WILL BE ABLY TO APPLY AGAIN FOR THE PROGRAM

____

Name of Parent or Guardian Signature

Please note that this is not a service covered by your insurance, including but not limited to Medicaid, Medical, etc.

CONSENT FORM / PARTICIPATION AGREEMENT

I give my child permission to participate in the Fit Club™ at the YMCA Fall Program. I understand that my child will engage in moderate to rigorous physical activity, learn about nutrition, be provided with a healthy snack, and participate in cooking demonstrations. I release the Fit Club™ Program and its employees from liability for any injuries, damages, or losses that might occur. I understand that the Fit Club™ Program and its personnel are not responsible for my child if he/she is not present in the program. The Fit Club™ Program runs Monday through Thursday and will begin at 230pm and end at 5pm, except on Wednesdays when the program begins at 130pm and ends at 4pm. My son/daughter has permission to walk home after the program ends. If he/she needs to leave the program before 5:00pm, I will provide him/her with a note or call (714) 549-6440 ext 2 to let program staff know that my son/daughter will be leaving early.

Signature of Parent or Legal Guardian Date

Authorization for Medical Treatment

In case of serious illness or accident, I authorize the Fit Club™ Program staff to seek medical treatment through 911 emergency services.

Signature of Parent or Legal Guardian Date

Student Medical Information

To my knowledge, my son/daughter is not allergic to any dairy products, nuts, or wheat products. My son/daughter does not have any medical condition that prohibits participation in moderate to rigorous physical activity.

Signature of Parent or Legal Guardian Date

If your child has a medical condition, allergy, or special need that we should be informed of, please provide detailed information below (include additional documentation if needed):

Testimonial and Photography Release

I hereby release, authorize, and give full consent to Dr.Riba's Health Club to publish and display my photograph, video, or testimonial in which myself, spouse, and or children appear. It is further agreed that the DrRHC may use or cause to be used material for, or in, visual displays, any exhibitions, internet web pages or publication for the purpose of communication to non-profit charitable partners of the DrRHC and the general public, provided that the DrRHC is credited when such material is used or printed. I acknowledge the DrRHC's right to crop any photographs and shorten testimonials at its discretion. I also acknowledge that the DrRHC may choose not to use my photo or testimonial at this time, but may do so at its own discretion at a later date. I also acknowledge that I have not received and will not request any monetary compensation for materials used pursuant to this release. I also declare by my signature below, that this testimony is factual and accurate.

Signature of Parent or Legal Guardian Date

Please note that this is not a service covered by your insurance, including but not limited to Medicaid, Medical, etc.