Age _____

Healing Hearts Registration

PARTICIPANT INFORMATION

Last Name _____ First Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Phone number _____ E-mail _____

Emergency Contact _____ Emergency Contact Number _____

Emergency Contact _____ Emergency Contact Number _____

PROGRAM INFORMATION

Classes □ Session dates: _____ List class or classes _____

After School □ days of week _____

PARENT/GUARDIAN INFORMATION

Last Name _____ First Name _____ E-mail _____

Phone number _____ Work number _____ Cell number _____

FEE

Total Cost: _____

HEALTH INFORMATION

The information you provide here will be held in the strictest confidence. It will be kept on file in our health binder or carried by the program director when your child is with us.

Child's Doctor's Name: _____ Phone Number: _____

Allergies: ☐ Yes ☐ No

If yes, please describe the severity of the reaction, requested accommodations and what is done to manage them.

_____

_____

May we serve your child food and beverages: ☐ Yes ☐ No

Medical, Physical, or Emotional Conditions (including Disabilities):

If your child does have any conditions, please provide information to assist us in providing the best program experience for your child.

_____

_____

Medications (including Inhalers): ☐ Yes ☐ No

PLEASE COMPLETE THE REVERSE SIDE OF THE FORM ⟶

If your child must take medication while in Healing Hearts Programs, please note here. All medications must be in their original containers and be appropriately labeled.

_____

_____

Is your child up-to-date on all state-required immunizations? ☐ Yes ☐ No

AUTHORIZATION OF CONSENT

(I) (We), the undersigned parent(s)/guardian(s) of _____, a minor, do hereby authorize any hospital for the undersigned to consent to any X-ray examinations, anesthetic, medical or surgical diagnosis or treatment, or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and/or surgeon licensed or any X-ray examination, anesthetic, dental or surgical diagnosis or treatment, or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any dentist licensed.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician or dentist, in the exercise of his/her best judgment, may deem advisable.

These authorizations shall remain effective until _____unless sooner revoked in writing delivered to said agent(s).

INDIVIDUAL CONTRACT

I am aware that exercise (i.e.: Cardio/Circuit, Weight Training, KMX (Krav Maga for Kids), Dance, Boxing, Yoga, Zumba, Sports Classes, Martial Arts, Boot Camp, and One on One Cardio Fitness Training and Sport Training for both kids and adults) can be physically stressful and in certain instances can even be harmful and result in death. I am also aware that any child or adult who has special needs such as neurological impairment, metabolic disease, low muscle tone, behavioral issues or who may have seizures are at increased risk of injury. Any child or adult who has ever had elevated blood pressure, is over 40 (men) and 42 (women) years of age, presently does not exercise, has had cardiac (heart) problems, is overweight, has diabetes, has any other cardiovascular problems or is susceptible to orthopedic problems is more at risk while exercising. I understand that I should consult with my personal physician before I begin any exercise program.

I understand that my participation in the Healing Hearts program and any other physical activity taking place at 48 Union Street Building #2, or in New Canaan sites, is voluntary and at my own risk and in consideration for my being permitted to use the facilities, I hereby release Healing Hearts and all of its members, any of its agents, or employees and agree to hold any and all of the released individuals or entities harmless against any liability arising out of my participation in any of the Healing Hearts programs or camps.

I have read this form and understand it. I have sufficient information to give me informed consent for my child to participate in programs.

_____ _____

Signature of Parent/Guardian of Minor Date

_____

Participants name

FOR OFFICIAL USE ONLY

PAID FEE: ☐ Yes ☐ No **Type of payment** ☐ Cash ☐ Check **Staff Initials:** _____