

\_\_\_\_\_  
Child's Last Name

\_\_\_\_\_  
Child's First Name

**EMERGENCY INFORMATION RECORD**  
**C.S. GYMNASTICS, INC.**

In case of an emergency, if you cannot reach me (parent/guardian), please contact:

Neighbor/friend \_\_\_\_\_ Phone# (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_

Parent \_\_\_\_\_ Cell Phone# (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_

Family Doctor \_\_\_\_\_

Address of Doctor \_\_\_\_\_

Phone# of Doctor (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_

Preferred Hospital \_\_\_\_\_

Learning/Physically challenged Yes No

If Yes, describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If child has ADD/ADHD, will he/she be medicated during class? Yes No

Check and describe if applicable:

Allergies Yes No \_\_\_\_\_

Required Medications Yes No \_\_\_\_\_

Previous Major Injuries Yes No \_\_\_\_\_

Chronic/Recurring Injuries Yes No \_\_\_\_\_

I verify the above information is true and accurate. In the event of an emergency, I understand that I will be notified as soon as possible.

I grant permission as parent/guardian for my child to be taken to the above stated preferred hospital.

Date \_\_\_/\_\_\_/\_\_\_\_\_ Parent/Guardian's Signature \_\_\_\_\_