Sign up online!

Winter Camp

Limited spaces available

2018 Winter Camp – Bowie

Select Your Session

Mon., Dec. 24	☐ Full Day	☐ Half Day	**Fri., Dec. 28**	☐ Full Day	☐ Half Day
Wed., Dec. 26	☐ Full Day	☐ Half Day	**Mon., Dec. 31**	☐ Full Day	☐ Half Day
Thur., Dec. 27	☐ Full Day	☐ Half Day			

IMPORTANT: MARYLAND STATE LAW REQUIRES CAMPERS TO BE 3-1/2 YEARS OLD & POTTY TRAINED TO ATTEND.

Full day *(8:30am-4:30pm)* – **$65/day**
Half day *(8:30am-11:30am)* – **$50/day**

☐ **Extended Mornings** *(8am-8:30am)* – **$5/day**
☐ **Extended Afternoons** *(4:30pm-6pm)* – **$15/day**

Pre-order lunch: Pizza – ☐ $3.50 for 1 slice & drink ☐ $5.50 for 2 slices & drink

Student's Name	**Age**	**DOB** *(mm/dd/yy)*	**Sex** *(m/f)*	**Last tetanus shot date** *(mm/yy)*	**Name of School** *(MD, other)*
Class			**Time**	**Day**	**Amount**
Student's Name	**Age**	**DOB** *(mm/dd/yy)*	**Sex** *(m/f)*	**Last tetanus shot date** *(mm/yy)*	**Name of School** *(MD, other)*
Class			**Time**	**Day**	**Amount**
Student's Name	**Age**	**DOB** *(mm/dd/yy)*	**Sex** *(m/f)*	**Last tetanus shot date** *(mm/yy)*	**Name of School** *(MD, other)*
Class			**Time**	**Day**	**Amount**
Home Address					**Home Phone**
City				**State**	**Zip**
Primary Contact Name	**Email**			**Cell #**	**Work #**
Secondary Contact Name	**Email**			**Cell #**	**Work #**
Family Physician	**Physician Phone**		**Emergency Contact Name**		**Phone**
Insurance Provider				**Group #**	
Does your child have any developmental or behavioral limitations, allergies, injuries or diagnosed illnesses?					
How did you find out about SSG? (*Bethesda Magazine***, *Families Magazine*, *Washington Parent*, *Your Health*, other)**					

We do not send confirmations. Assume your first choice has been accepted.

Parent's Signature & Liability Waiver must be signed before your child participates in any gym activities

Release agreement: I understand that any athletic activity is inherently dangerous. The above named student has had a medical examination within the last twelve months and is capable of participating in gymnastics. In the event of injury or illness, every effort will be made to contact the parent or guardian. If necessary, I authorize *Silver Spring Gymnastics & Fitness Club, Inc.* and *Silver Stars Gymnastics, Inc.* to administer first aid and/or authorize medical treatment. Students are expected to carry their own accident and medical insurance. I agree to be responsible for any medical bills incurred resulting from illness or injury during my child's participation at *Silver Spring Gymnastics & Fitness Club, Inc.* and *Silver Stars Gymnastics, Inc.*

BY SIGNING THIS RELEASE, I UNDERSTAND THE POLICIES AND LIABILITIES THAT MAY OCCUR IN SPORTS ACTIVITIES.
I UNDERSTAND THERE ARE NO REFUNDS OR CREDITS GIVEN.

Photograph Release: I agree to allow my child's likeness to be used on the website and in promotional materials for Silver Spring Gymnastics & Fitness Club, Inc. and Silver Stars Gymnastics, Inc.

Date_____ **Signature (parent or guardian)** _____

Class Amount $ _____

Visa/MasterCard/AMEX Number _____ Expiration Date _____

3 digit CIN *(found on back of card)* _____ Name of Card Holder _____

Signature of Card Holder _____

Payment Policies — Payment is due at time of registration. We have a strict **NO REFUND** policy and you may not transfer monies to another session. **REMEMBER**, you are paying for your child's spot in class – not his/her attendance.

I, _____ **authorize Silver Spring Gymnastics & Fitness Club, Inc.and Silver Stars Gymnastics, Inc. to charge the amount above to my credit card.**
I understand there are no refunds or credits.

Return to Silver Stars Gymnastics
2701 Pittman Drive, Silver Spring MD 20910
301-589-0938 • Fax 301-589-1717

14201 Woodcliff Ct., Bowie, MD 20720
301-352-5777 • Fax 301-352-8414

For Office Use Only

Date _____ Charged by _____
Amount _____ Entered/Date _____
Ref # _____ Initials _____