



Sign up online!

Winter Camp

Limited spaces available

2019 Winter Camp – Bowie



Select Your Session

- | | |
|---|--|
| Mon., Dec. 23 <input type="checkbox"/> Full Day <input type="checkbox"/> Half Day | Fri., Dec. 27 <input type="checkbox"/> Full Day <input type="checkbox"/> Half Day |
| Tue., Dec. 24 <input type="checkbox"/> Full Day <input type="checkbox"/> Half Day | Mon., Dec. 30 <input type="checkbox"/> Full Day <input type="checkbox"/> Half Day |
| Thur., Dec. 26 <input type="checkbox"/> Full Day <input type="checkbox"/> Half Day | Tue., Dec. 31 <input type="checkbox"/> Full Day <input type="checkbox"/> 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) – \$70/day

Extended Mornings (8am-8:30am) – \$5/day

Half day (8:30am-11:30am) – \$55/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 \$ _____

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

 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.

For Office Use Only

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