REGISTRATION & LIABILITY WAIVER

REGISTRATION FEE IS NON-REFUNDABLE

PARENTS' NIGHT OUT

44693 Brimfield Drive – Ashburn, VA 20147 – 703.858.2200

INDIVIDUAL (Class, Clinic, Camp, or Event) Registration

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL/WORK PHONE: _____

BIRTHDATE: _____ AGE: _____ MALE / FEMALE

E-MAIL ADDRESS: _____

EMERGENCY CONTACT: _____ EMERGENCY PHONE: _____

For Registrants Under 18 Years of Age

PARENT/GUARDIAN: _____

PARENT/GUARDIAN HOME PHONE: _____ CELL/WORK PHONE: _____

PARENT/GUARDIAN: _____

PARENT/GUARDIAN HOME PHONE: _____ CELL/WORK PHONE: _____

REGISTERING FOR (CIRCLE ALL THAT APPLY): The Fitness Equation Parent's Night Out
$20 per Member / $30 per Non-Member

TOTAL REGISTRATION FEE: _____

I/we do hereby acknowledge, recognize, and accept the inherent risk of bodily injury, disability, paralysis, and/or death to myself/ourselves and/or my/our child(ren) that exists as a result of my/our participation in any athletic endeavor, and specifically by my/our participation in athletic endeavors offered or hosted by The Fitness Equation. As such, I/we do hereby agree to save hold harmless and indemnify The Fitness Equation, it's owners, employees, agents, and other individuals or entities operating on behalf of The Fitness Equation, for any bodily injury, disability, paralysis, and/or death, that I/we and or my/our child(ren) may sustain as a result of my/our participation in any athletic endeavor offered by The Fitness Equation.

In the event that I/we and or my/our child(ren) suffer some type of injury or illness which requires immediate medical treatment, I/we do hereby consent to and authorize the administration of such first aid and/or medical treatment to myself/ourselves and or my/our child(ren) by employees and/or agents of The Fitness Equation trained to administer such first aid and/or medical treatment. I/we do further consent to and authorize employees and/or agents of The Fitness Equation to arrange for ambulance transportation for an appropriate medical facility for me/us and/or child(ren).

SIGNATURE: _____ DATE: _____
Parents: Please sign on behalf of yourself(ves) and your child(ren) under 18 years of age

Office Use Only (Payment Information): Payments must be made/collected at facility address by authorized staff only: 44693 Brimfield Drive, Ashburn, VA 20147.

Cash

Amount Received: _____

Staff: _____ Date: _____

Accounting: _____

Check

Amount Received: _____

Check #: _____

Staff: _____ Date: _____

Accounting: _____

Credit Card

Amount Received: _____

Expiration: _____ Last 4: _____ Type: _____

Name on Card: _____

Staff: _____ Date: _____