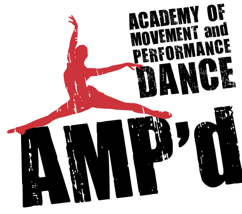

Fitness Form

Name: ____ Date: _____________

Parent/Guardian Name(s): ____

Email: ____

Street Address: ____

Town/City: ____________________________ State: _________ Zip Code: _______________

Phone #: _________________________________ Cell #: ______________________________

Emergency Contact: ___________________________________ Phone #: ________________

Medical Conditions, Injuries and/or Allergies: _____________________________________

____

Group Class Registration:

Drop In ______ =$15 ---- 10 pack ______=$120 Day/Time: ______________

Private Sessions:

1hr Sesion: ______ =$55 ---- 10 pack _______ Day/Time: ______________
# of Add on ______ $20 per person

____ ____________________
Signed Date

Amount Due: $ ______________________

Amount Paid: $ ______________________ Cash Check #: __________