17379 Edison Avenue
Chesterfield, MO 63005
Tel: (636) 530-4550
Fax: (636) 537-8427

SkyRobics Membership Registration

1. All SkyRobics members must complete a full registration packet each year. Memberships may be renewed monthly. After twelve months, a new registration must be completed.
2. Minors must be cosigned by their parent or legal guardian.
3. In addition, a Sky Zone liability waiver must be signed by the participant or legal guardian.
4. Providing false information may result in disqualification from Sky Zone memberships.

Participant Information		
Participant Name (First, Last)	Home Phone #	
Address (#, street, unit), City, Zip Code	Cell #	
Bus. #	Email Address*	
Emergency Contacts – Please list the names and telephone numbers of two people we can contact in the event of an emergency. Also, please indicate their relationship to you.		
Name/Relationship to Participant	Phone #	Cell
Name/Relationship to Participant	Phone #	Cell

Sky Zone members may be contacted via email about schedule changes, SkyRobics/Sky Zone updates, or special offers/discounts. Emails will not be sold or disclosed to third party individuals or organizations.

Health History & Customer Information

Date: _____

Name: _____ Birth Date: _____

How did you year about SkyRobics (circle one):

Friend TV Inside the facility Direct Mail Other

Does your physician know that you are participating in this exercise program? _____

Describe your current exercise program: _____
_____

Do you have now or have you had in the past: (Please check √ if YES)

____ History of heart problems
____ Increased blood pressure
____ Any chronic illness or condition
____ Difficulty with physical exercise
____ Advice from a physician not to exercise
____ Recent surgery
____ Pregnancy (now or within the last 3 months)
____ History of breathing or lung problems
____ Hernia or any condition that may be aggravated by strenuous exercise
____ Muscle, joint, or back disorder, or any previous injury still affecting you
____ Diabetes or thyroid condition
____ Cigarette smoking habit
____ Increased blood cholesterol
____ History of heart problems in family

If you have answered **YES to one or more questions, we recommend that you consult a physician before participating in any SkyRobics classes.

I understand that the staff employed at this facility is not qualified to make medical assessments of my health or my physical ability to attend this exercise program, and it is my responsibility to check with my physician before starting any exercise program.

Signed: _____ Date: _____

SkyRobics Membership Options

Check One	Membership Type	Price/Month ($)	Description
□	Monthly	$40	• No Initiation Fees or Enrollment Fees • UNLIMITED access to SkyRobics Fitness Classes
□	Summer	$100	• Unlimited classes, Memorial Day through Labor Day

Office Use Only

Date Paid:	___ Cash		Date:	_____
Amount Paid:	___ C.C.	# _____	Receipt #	_____
Employee:	___ Check	# _____	Signature:	_____

Credit/Debit Card Authorization

Name of Credit Card Holder (print): _____

Address of Credit Card Holder (print): _____

Credit Card Number: _____ Expiration Date: _____

____ VISA ____ MasterCard ____ Check/Debit Card

Please pay and charge to my account, all drafts by Sky Zone Recreational Center to its own order once each month in the amount of $ _____.

Beginning _____

This authorization will remain in effect until I have canceled this agreement in writing. Until Sky Zone receives such notice, I agree that Sky Zone shall be fully protected in honoring such draft. I agree that your treatment of each such draft and your rights in respect to it, shall be the same as if it were signed by me.

Date: _____ Signature: _____

Member's Right to Cancel

If you wish to cancel this contract, you may cancel by delivering or mailing a written notice to Sky Zone Recreational Center within (3) business days before the next monthly renewal date. This notice must say that you do not wish to be bound by the contract and must be delivered or mailed before midnight on the third business day after you sign the contract. The notice must be delivered or mailed to Sky Zone RECREATIONAL CENTER, 17379 EDISON AVENUE, CHESTERFIELD, MO 63005 TEL: 636-530-4550. If you cancel within said three (3) business days, Sky Zone Recreational Center will return, within ten (10) business days of the date on which you gave notice of cancellation, any payments you have made.

INITIAL:

_____ I agree that this facility offers the programs, equipment, services, and hours of operation that I desire to help me reach my fitness goals.

_____ I am physically able to perform the exercise program and have no limitation either physically or financially that would hinder me from fulfilling this agreement.

_____ I, the member, understand that I cannot transfer this membership to any other person nor is any portion of my membership refundable after three business days. I understand that I may cancel this membership within three days of enrollment by notifying this facility of my desire to do so by certified mail or in person.

_____ I understand I cancel my membership if the premises should become damaged or destroyed by fire, flood, tornado, other casualty or condemnation unless there have been no scheduled classes for more than 30 days at the facility. My membership status will be considered a hold at this time.

_____ I do hereby release this facility and its employees from any claim or cause of action, which may have occurred as a result of any medical problem known or unknown, which I presently have or later develop. I understand that the staff employed at this facility is not qualified to make medical assessments of my health or my physical ability to attend this exercise program and it is my responsibility to check with my physician before starting any exercise program.

_____ I verify that no promises or guarantees other than those written on this agreement was made to me by this facility or its employees. I agree to follow the instructional guidelines and to cooperatively utilize the facilities with other members. Failure to do so may result in cancellation of my membership.

_____ I understand that if I fail to pay the amount owed by this agreement, whether I have used the facility or not, within the time stated, this facility has the right to collect the balance of this agreement and at its option, turn the balance over to collections. I understand I will be responsible to pay all collection fees up to 50% and attorney fees as awarded by the court.

_____Sky Zone will not extend or put any memberships on hold due to personal issues such as travel, injury, sickness and more

YOUR SIGNATURE CERTIFIES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO THE TERMS AND CONDITIONS.

Date: _____

Member's Signature: _____ Member's Printed Name: _____