17379 Edison Avenue
Chesterfield, MO 63005
Tel: (636) 530-4550
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SkyRobics Registration

1. All SkyRobics participants must complete a registration form each year.
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.

Health History & Customer Information

Date: _____

Name: _____ Birth Date: _____

How did you year about SkyRobics (circle one):

Friend TV Inside the facility Direct Mail Other

Person to contact in case of emergency: _____

Relationship: _____ Phone: _____

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: _____

Member's Printed Name: _____