Date Rec'd _____

Time Rec'd _____

Breakfast with Santa 2016

Family Name: _____ **HQ Member #** _____

Daytime Phone #: _____ **Cell Phone #:** _____

Email Address: (needed for confirmation) _____

Assigned Seating – Email notification will be sent when tickets are ready for pick up

Adult Member: $20.00 each (13 years & up) Child Member: $10.00 (12 months & under FREE)

Name: _____**Age:**_____ **Name:** _____**Age:**_____

Name: _____**Age:**_____ **Name:** _____**Age:**_____

Name: _____**Age:**_____ **Name:** _____**Age:**_____

GUESTS: Limit 4 Guests per Family Membership:
Adult Guest: $25.00 each (13 years & up) Child Guest: $15.00 (12 months & under FREE)
This must be done at the Program Desk at the time of your registration.

Name: _____ **DOB:** ____/____/____ **Name:** _____ **DOB:** ____/____/____

Name: _____ **DOB:** ____/____/____ **Name:** _____ **DOB:**____/____/_____

ALL ATTENDEES MUST BE REGISTERED REGARDLESS OF AGE

Total Due: _____

No Refunds issued once registration form is received and payment has been processed**.**

RELEASE STATEMENT:
I, the parent/guardian of the registrant, a minor, or an adult registrant of legal age, agree that the registrant and I will abide by the rules of HealthQuest of Central Jersey, LLC., its affiliated organization and sponsors. Recognizing the possibility of physical injury associated with leagues and in consideration for HealthQuest of Central Jersey, LLC., accepting the registrant for its league programs and activities, I hereby release, discharge, and/or otherwise indemnify HealthQuest of Central Jersey, LLC.,, its officers, coaches, managers, referees, its affiliated organizations and sponsors, their employees, and associated personnel, including the owners of the fields and facilities utilized for the league program, against any claim by or on behalf of the registrant as a result of the registrant's actions. I affirm that the registrant is in sound physical and healthy condition and that the athlete is covered by health/accident insurance secured independently. As parent/guardian or the registrant, I hereby give my permission for the participant of the program to be transported for emergency medical care. I hereby authorize consent for emergency medical care prescribed by a duly licensed Doctor or Medicine or Doctor of Dentistry. This care may be given under whatever conditions necessary to preserve life, limb or well being of my dependent.

Method of Payment:

☐ Cash ☐ Check #_____ ☐ Charge to HQ Account – Scan Card #_____

☐ Credit Card – Circle One: Amex Discover MasterCard Visa

Card Number: _____ Exp Date: _____

Customer Signature: _____ Date: _____

Completed form can be emailed to programdesk@healthquest-fitness.com

Office Use only: POS _____ CSI _____ # Tickets _____ Adult _____ Child _____ Table # _____