

# Breakfast with Santa 2017

Date Rec'd \_\_\_\_\_

Time Rec'd \_\_\_\_\_

Family Name: \_\_\_\_\_ HQ Scan # \_\_\_\_\_

Daytime Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Email Address: (needed for confirmation) \_\_\_\_\_

**Assigned Seating – Email notification will be sent when tickets are ready for pick up at the Front Desk**

**Adult Member: \$25.00 each (13 years & up)**  
**Child Member: \$15.00 (12 months & under FREE as a lap chid)**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

**GUESTS: Limit 4 Guests per Family Membership:**  
**Adult Guest: \$30.00 each (13 years & up)**  
**Child Guest: \$20.00 (12 months & under FREE as a lap child)**  
**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](mailto:programdesk@healthquest-fitness.com)**

Office Use only: POS \_\_\_\_\_ CSI \_\_\_\_\_ # Tickets \_\_\_\_\_ Adult \_\_\_\_\_ Child \_\_\_\_\_ Table # \_\_\_\_\_