

Breakfast with Santa 2019

Date Rec'd _____

Time Rec'd _____

Member Name: _____ HQ Scan # _____

Cell Phone #: _____ Email Address: _____

Assigned Seating – If you would like to be seated with another family all registration forms must be submitted together. Once Seating arrangements are made there will be no adjustments.

Adult Member: \$27.50 each (13 years & up)

Child Member: \$15.00 (12 months & under FREE as a lap child)

All members attending MUST be listed

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

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

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

GUESTS: Limit 4 Guests per Family Membership:

Adult Guest: \$32.50 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 (including lap child)

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 of 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 # _____ Credit Card Club Charge (CC on file)

Card Number: _____ Exp Date: _____

Customer Signature: _____ Date: _____

Email completed form to programdesk@hqfit.com

For Office Use Only:

CA _____ POS _____ # Adults _____ # Children _____ Under 1 _____ # Tickets _____ Table # _____