



**HEALTHQUEST**  
FITNESS CLUB

**Mark the Session you are registering for:**

**NEXT AVAILABLE REVIEW CERTIFICATION**

**American Red Cross Lifeguard Certification Course**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ Birthday: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

*\*Participant must be a member to receive member price*

- Must attend all classes
- No refunds will be given after the class has started
- Class must have a minimum of 6 participants and will be cancelled if that number is not met
- Participants must be 15 years old
- Must be able to swim 300 yards continuously, tread water for 2 minutes using only legs
- Complete a timed event within 1 minute, 40 seconds – Starting in the water, swim 20 yards, surface dive to a depth of 7-10 feet to retrieve a 10-pound object. Return to the surface and swim 20 yards on the back to return to the starting point. Exit the water without using a ladder or steps.

**Review Certification (12 hours):**

[ ] \$250

Course Date TBA – Dependent upon minimum number of participants. Once required number of registrants is met, confirmation of course date will go out.

**WAIVER OF LIABILITY**

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:**

(PLEASE CIRCLE)

Cash

Check

Credit Card

Member Charge

CC Number \_\_\_\_\_ Exp Date: \_\_\_\_\_ CVV \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_