

HEART OF CHAMPIONS BOXING

Registration Fee:

Adults- \$120.00

Children- \$100.00

Price Includes: head gear, one set of hand wraps and standard official boxing gloves.

Rates:

\$105.00-110.00 - 4 Workouts = 1 Session Per week/ Per Month Training

\$115.00-120.00 - 8 Workouts = 2 Sessions Per Week/Per Month Training

\$125.00-135.00 - 12 Workouts = 3 Sessions Per Week/Per Month Training

\$145.00-155.00 - 16 Workouts = 4 Sessions Per Week/Per Month Training

\$160.00-170.00 - 20 Workouts = 5 Sessions Per Week/Per Month Training

Includes:

- Weekly Performance evaluation with Instructor/Trainer.
- Weekly Nutrition & Diet Plan Consultation.
- Weekly Drugs & Gang Related Awareness Lectures & Handouts.
- No obligation, No Contract, No Membership Fees, No Hidden Costs

T.O.P

\$40.00 - 1 Session - 1 Hour Training

After the (T.O.P), if you decide that the training program is good for you or your young boxer, it's up to you to call and let us know you wish to continue. We will not call you after (T.O.P) to pressure you to join. It is entirely up to you. If you do choose to join us, the (T.O.P) fee will go towards your registration fee.

If you need to cancel a session for some reason or another, Do not worry, you will be able to make it up.

Please call in advance for non-attendance

1-on-1 & Competitor Boxing Rates

\$55.00 per hour

Registration and Sessions Fees ARE NON- REFUNDABLE

ALL FEES & The First Months Class are due together

HEART OF CHAMPIONS BOXING REGISTRATION FORM

(Please Print)					
Today's date:			BOX FOR OFFICE USE ONLY: STUDENT NUMBER:		
STUDENT INFORMATION					
Student's last name:		First:	Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Is this your/child's legal name?	If not, what is student's legal name?	Birth date:	Age:		Social Security number:
<input type="checkbox"/> Yes <input type="checkbox"/> No		Email Address:			
Street address:			P.O. box:		City:
State:	ZIP Code:	Home phone number: ()	Cell: ()	Work: ()	
Where did you hear about us?	<input type="checkbox"/> Friend	<input type="checkbox"/> Family	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other Specify:	
Do you know of anyone who might be interested in Boxing?		If so, Name and Address:			
PARENT INFORMATION (REQUIRED IF UNDER 18)					
(Please Print)					
Mother's Last Name:		First Name:		Middle Name:	
Street Address: (if different)		Home phone no.: ()	Work: ()		Cell: ()
Father's Last Name:		First Name:		Middle Name:	
Street Address: (if different)		Home phone no.: ()	Work: ()		Cell: ()
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):			Relationship to student:	Home phone number: ()	Work phone number: ()
The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance owed to Heart of Champions Boxing. I also, give permission to Heart of Champions Boxing to instruct and train me /my child in the art of boxing and, I am aware that I am required to sign and fill out all forms before beginning training.					
_____ <i>Student/Parent/Guardian signature</i>				_____ <i>Date</i>	

LIABILITY RELEASE, WAIVER, DISCHARGE, AND COVENANT NOT TO SUE

This is a legally binding Release made by me, _____, to Heart of Champions Boxing.

I, the undersigned fully recognize that there are dangers and risks to which I may be exposed by participating in Boxing Training and Exercises as Heart of Champions Boxing during classes. I understand that Heart of Champions Boxing does not require me/my child to participate in the Boxing training and exercises that are being offered, but I want to do so, despite the possible dangers and risks and despite this Release.

I therefore agree to assume and take on myself all of the risks and responsibilities in any way associated with this activity. In consideration of and in return for the training being offered to me or my child by Heart of Champions Boxing, I release Hocboxing, (or its employees) from any and all liability, claims and actions that may arise from injury or harm to me, from my death or from damage to my property in connection with this activity. I understand that this Release covers liability, claims and actions caused entirely or in part by any acts or failures to act of the Heart of Champions Boxing (or its employees), including but not limited to negligence, mistake, or failure to supervise by Hocboxing.

I recognize that this Release means I am giving up, among other things, rights to sue Heart of Champions Boxing and D & G Expressions, and its employees for injuries, damages, or losses I may incur. I also understand that this Release binds my heirs, executors, administrators, and assigns, as well as myself.

I have read this entire Release; I fully understand it and I agree to be legally bound by it.

THIS IS A RELEASE OF YOUR RIGHTS. READ CAREFULLY BEFORE SIGNING.

(Signature)

(Parent or Guardian Signature if Releaser is under 18 years old)

(Date)

As, a Certified Medical Assistant and CPR certified Trainer/Instructor I will make sure in the event of injury that the proper medical procedures are followed and family/emergency contact(s) are notified promptly of any incidents that occur.

James Overbey (Owner/Trainer/Instructor)

**HEART OF CHAMPIONS BOXING
PHYSICAL ASSESSMENT FORM**

(This part of the form is to be completed by the Boxing Participant or Parent.)

Date: _____

Participant Details

Name: _____ Age: _____ Date of Birth: _____

Address: _____ State: _____ Zip: _____

Phone: _____ Email: _____

General Information- Please Respond Yes or No. Provide Comment for any “yes” answers.

Do you have allergies? _____ Comment: _____

Are you taking any medication? _____ Comment: _____

Have you ever had a heart murmur? _____ Comment: _____

Have you ever had an irregular heartbeat? _____ Comment: _____

Has anyone in your family died prior to age 40? _____ Comment: _____

Have you ever been hospitalized overnight? _____ Comment: _____

Have you ever had surgery? _____ Comment: _____

Have you ever had a serious injury ? _____ Comment: _____

Have you ever had a head injury? _____ Comment: _____

Have you ever had x-rays? _____ Comment: _____

Have you ever had a broken bone? _____ Comment: _____

Have you ever had a sprain/strain/dislocation? _____ Comment: _____

Have you ever had a “stinger/burner?” _____ Comment: _____

Have you ever passed out? _____ Comment: _____

Have you ever had chest pain? _____ Comment: _____

Have you ever had high blood pressure? _____ Comment: _____

Have you ever had a seizure? _____ Comment: _____

Have you ever had heat cramps/exhaustion/stroke? _____ Comment: _____

Do you have any of the following chronic diseases or illnesses: Provide answer below.

(Asthma, Diabetes, Hepatitis, Marfan’s Syndrome, Monucleosis, Sickle Cell, Kidney Problems, Frequent Headaches, etc.) _____ Comment: _____

Have you ever had any skin conditions? _____ Comment: _____

Do you wear glasses, contacts, braces, appliances? _____ Comment: _____

Has it been more than 5 years since your last tetanus shot? _____ Comment: _____

Do you have any concerns to discuss with the provider? _____ Comment: _____

Do you use any nutritional supplements? _____ Comment: _____

I authorize the release of Heart of Champions Boxing from this and any information that may affect my participation in the Boxing program. I furthermore know of and accept the risks involved in participation in athletics and understand that serious injury, even death, is possible in such participation and voluntarily choose to accept such risks.

Participant/Parent Signature: _____ Date: _____

**HEART OF CHAMPIONS BOXING
PHYSICAL ASSESSMENT FORM**

(This part of the form should be filled completely by a nurse, doctor, physician or a medical practitioner or their assistants.)

Health condition

Height: _____ Weight: _____

Vision: Left: ____/____ uncorrected /corrected _____

Right: ____/____ uncorrected /corrected _____

Glasses _____ Contacts _____

Blood pressure ____/____ Pulse _____ Hearing _____

Body – Please write: Normal or Abnormal. If abnormal please provide a comment.

Mouth, Throat and Teeth _____ Comment: _____

Eyes, Nose and Ears _____ Comment: _____

Thyroid and Neck _____ Comment: _____

Cardiovascular _____ Comment: _____

Lungs and Chest _____ Comment: _____

Abdomen _____ Comment: _____

Skin _____ Comment: _____

Genitalia _____ Comment: _____

Musculoskeletal

Neck, Shoulders and Arms _____ Comment: _____

Hands, Hips and Back _____ Comment: _____

Feet, knees and legs _____ Comment: _____

Neurological _____ Comment: _____

Women only (If applicable)

Has patient had any abnormal pap smears or breast exams? _____

Does Patient have regular menstrual cycles? _____

Please comment on whether further evaluation or care is needed

Does the patient smoke cigarettes? _____ for how long? _____

Does the patient drink Alcohol? _____ for how long? _____

Participation – Please Respond Yes or No. If No please comment.

Is Full Participation Allowed? _____ Comment: _____

Assessor name _____ Position: _____

Signature: _____ Date: _____