

Gene Mills Clinic / May 14, 2011

REGISTRATION FORM

Each Session: \$60.00 Per Wrestler
\$75.00 For Limited Walk-Ins

LIMITED SPOTS AVAILABLE – Mail Today!

Name _____ DOB _____
(please print)
Age _____ Seasons Wrestled _____ Approximate Weight _____
School _____ Current Grade _____
Address _____
Parents/Guardians _____
Phone (home) _____ Phone (cell) _____

Check Box: Morning Session

(Grades 2-6 only)
9:00am to 12:00pm

Afternoon Session

(Grades 7-8 only)
12:15pm to 3:30pm

Medical

Allergies _____ Medications needed _____
Medical Condition(s) _____

Emergency Contacts

Name _____ Phone _____
Physician _____ Phone _____
Insurance Company _____
Policy Number _____ Group Number _____

In case of injury or illness I request that the Sparta Pride Club coaches and guest clinicians contact me. If I cannot be reached, I authorize the coaches and clinicians to call the above named emergency contacts or physician for treatment. If the above are unavailable, I authorize the coaches and clinicians to seek treatment and this document will serve as permission for authorized medical personnel to treat my child. I hereby hold harmless Sparta Pride, it's coaches, board members, clinicians and all those affiliated with Sparta Pride LLC from and against all loses, claims, damages, penalties relating to claims arising from the participation in the Sparta Pride program and Camp of Champs Series.

I hereby give permission to allow a recognizable image of my child, still or video, in a newspaper, news broadcast or Sparta Pride Internet web page or advertising material in connection with an event, award, or activity at a Sparta Pride event. I understand that their name, hometown and state can be attached to said image at the time of publication. I understand that this event is subject to change.

Parent/Guardian Signature _____
Email Address _____

Mail Checks Payable To: Sparta Pride LLC. – PO Box 621 – Sparta – NJ – 07871

***One form required per participant.**