

REACH BASKETBALL MINI-CLINIC 2009 REGISTRATION FORM

Fee: \$70.00

T-Shirt Size: [] S [] M [] L [] XL
(Shirts are based on adult sizes).

Name: _____ Age: _____ Home Phone: _____

Address: _____ City & Zip: _____

School: _____ Grade: _____

Parent/Guardian: _____ Phone Number: _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Home Phone No. _____ Cell No: _____ Work No: _____

Authorized individuals to drop-off/pick-up from the clinic:

Name: _____ Relation: _____

Name _____ Relation: _____

Any allergies or injuries camp attendant should be aware of: _____

Please list any medication your child is now taking or is allergic to: _____

Medical insurance: Yes [] No [] Medical Insurance Carrier: _____ Policy No. _____

LIABILITY RELEASE AND MEDICAL CONSENT FORM

In consideration of being accepted by Calvary Chapel Pearl Harbor for participation in all activities of the REACH 3-DAY Basketball Mini-Clinic, We (I) do for ourselves (Myself) hereby release, forever discharge and agree to hold harmless Calvary Chapel Pearl Harbor, its directors, employees and agents thereof from any and all liability, claims or demands for personal injury, sickness, death, losses or damages which may be incurred by the undersigned while participating in the CCPH Basketball Clinic.

We (I) further hereby agree(s) to hold harmless and indemnify Calvary Chapel Pearl Harbor, its directors, employees, and agents from any and all liability and claims arising from the negligent, willful or intentional acts of said participant, including expenses incurred attendant thereto.

WE (I) consent to and authorize any medical treatment or care to the above-named child in the event of any injury or illness resulting from participation in the REACH 3-Day Basketball Clinic. The undersigned agrees and shall be liable to pay all costs and expenses incurred in connection with such medical services and to discharge and hold harmless Calvary Chapel Pearl Harbor, its directors, employees and agents against any liability and claims resulting from or connected with such medical treatment or care. I have read and I understand the content of the liability release and medical consent form.

Parent/Guardian Name: _____ Signature: _____ Date: _____

If registering by mail, please make check or money order payable to *CALVARY CHAPEL PEARL HARBOR* and mail registration form to:

Calvary Chapel Pearl Harbor
REACH Basketball Clinic
94-1044 Waipio Uka Street
Waipahu, HI 96797

Limited Scholarship Funding Provided

For office use only: Date paid: _____ Cash: _____ Check No: _____ Received by: _____