



# MAD SKILLZ Field Hockey Academy



www.the422sportsplex.com ♦ 1400 Industrial Hwy ♦ Pottstown, PA 19464 ♦ 610.323.9600

## Intermediate Skillz Ages 10 - 14

### The Program

Participants in the Intermediate Skillz field hockey clinic will receive 7 weeks of personal instruction. The goal of this clinic is to take your child's field hockey ability to the next level. Players perfect the skills they have learned while acquiring new abilities that will give them an edge on the field.

### Payment Information

See website for costs. Please return this form along with full payment to hold a spot for your child in your requested class session. Acceptable forms of payment are check, cash, Visa or MasterCard. The 422 SportsPlex has a "No Refund" policy.

### Class Schedules

Please check website for dates and times available: We must have a minimum of 10 children to begin a class.

Class Start Date \_\_\_\_\_ Day of Week \_\_\_\_\_ Time requested \_\_\_\_\_

### Player Information

Today's Date \_\_\_\_\_

Participant Name \_\_\_\_\_  Male  Female Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Mom Name \_\_\_\_\_ Dad Name \_\_\_\_\_

Mom Emergency Number \_\_\_\_\_ Dad Emergency Number \_\_\_\_\_

Mom Work Phone \_\_\_\_\_ Dad Work Phone \_\_\_\_\_

Mom Email \_\_\_\_\_ Dad Email \_\_\_\_\_

In signing this application, I release The 422 SportsPlex, Mad Skillz Field Hockey Academy & other involved parties from any claims or responsibility for injuries suffered in this class/league. I knowingly assume all risks associated with my child's participation, even if arising from negligence of the participants or others, and assume full responsibility for my child's participation. I certify that my child is in good physical condition and can participate in this class/league. Further, I authorize the site director to request medical treatment as necessary to insure my child's well being.

If under the age of 18, a parent or guardian's signature is required. Please print except for signature.

Athlete Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Health Insurance Provider \_\_\_\_\_ Policy # \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Please indicate any medical or special needs that our staff should be aware of. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Payment Method Used  Cash  Check (Check # \_\_\_\_\_)  Charge (circle) MasterCard Visa

Credit Card # \_\_\_\_\_ Exp \_\_\_\_\_ Code \_\_\_\_\_ Amount \_\_\_\_\_ Initials \_\_\_\_\_