

SMOKE RISE JUNIOR TENNIS CLINICS

REGISTRATION FORM

By filling out this form I wish to participate in the Smoke Rise Junior Tennis Clinics

PARTICIPANTS FIRST & LAST NAME: _____

STREET: _____

CITY, STATE, ZIP: _____

AGE: _____ SCHOOL: _____ GRADE: _____

PARENT/GUARDIAN NAME: _____

HOME PHONE: _____ WORK/CELL PHONE: _____

EMAIL: _____

CLINIC DAYS (PLEASE CIRCLE ONE): WEDNESDAY THURSDAY SATURDAY

CLINIC MONTHS (PLEASE CIRCLE ONE): MARCH APRIL MAY

CREDIT CARD AUTHORIZATION FORM: PLEASE FILL IN ALL REQUESTED INFORMATION BELOW

CARDHOLDER NAME: _____

CREDIT CARD BILLING ADDRESS: _____

CREDIT CARD: MASTERCARD ____ VISA ____ AMERICAN EXPRESS ____ DISCOVER ____

CREDIT CARD NUMBER: _____ EXP. DATE _____

PROGRAM WITHDRAWAL: WE REQUIRE A 10-DAY WRITTEN NOTICE FOR WITHDRAWAL FROM THE PROGRAM. IN THE ABSENCE OF A 10-DAY NOTICE, A MONTHLY DRILL CHARGE WILL BE ASSESSED.

CHILD PARTICIPATION WAIVER: I GIVE MY PERMISSION FOR MY CHILD TO PARTICIPATE IN TENNIS PROGRAMS AT SMOKE RISE COUNTRY CLUB AND HEREBY RELEASE/WAIVE ANY AND ALL RIGHTS AND CLAIMS FOR DAMAGE I MIGHT HAVE AGAINST THE SMOKE RISE COUNTRY CLUB AND ITS AGENTS FOR ANY AND ALL INJURIES, WHICH MAY BE SUFFERED BY MY CHILD IN CONNECTION WITH PARTICIPATION IN THIS PROGRAM. I AUTHORIZE USE OF THE CREDIT CARD PROVIDED FOR PAYMENT ONLY FOR PROGRAMS REGISTERED FOR IN THE JUNIOR TENNIS PROGRAMS.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

