



PLAYMAKER CLINIC REGISTRATION

ATHLETE NAME _____ AGE _____ DOB _____

CURRENT GRADE _____ CURRENT SCHOOL ATTENDING _____

PARENT/GUARDIAN NAME(S) _____

ADDRESS _____

HOME PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

PLAYMAKER CLINIC FEES/DATES/TIMES

FEBRUARY 4, 11, 18, 25

LAKESHORE ATHLETIC CLUB – FLATIRON

GIRLS SESSION: 6TH-9TH GRADE 1-2:30PM

BOYS SESSION: 6TH-9TH GRADE 2:30-4PM

COST: \$69 ALL 4 CLINICS *\$30 SINGLE SESSION – SPACE LIMITED!

***PAYMENT PROCESSED AT WWW.GEOFFGOLDEN.COM**

RECEIPT# _____

PLEASE READ THE FOLLOWING CAREFULLY, THEN SIGN AND DATE BOTTOM
I, the undersigned, submit my child is physically fit to participate in strenuous activity and waive Geoff Golden Basketball LLC, Geoff Golden, all staff, and the institution providing the facilities of any or all responsibility for injury, recurrence of any liabilities or causes of action arising out of or in connection with my child's participation with the Playmaker Clinics or Geoff Golden Basketball LLC. I agree that my signature is a commitment to make full payment for the session and understand that no refunds are granted regardless of circumstance.

Parent/Guardian Signature _____ Date _____

