



CITYVIEW SQUASH YOUTH CLINIC APPLICATION – SEMESTER 3, SPRING 2019

General Information

Student's Name			
Address			
City		State:	Zip:
Email Address			
Phone Number		Cell Number:	
Date of Birth		Gender: M <input type="radio"/> F <input type="radio"/>	
School			
Parent/ Guardian			
	Name	Email	Phone
Parent/Guardian			
	Name	Email	Phone
		Cell Phone	

Sessions

Sunday	Tuesday	Thursday	Friday
10:30am to 11:30am	4:30pm to 5:30pm	4:30pm to 5:30pm	4:30pm to 5:30pm
14 Sessions	14 Sessions	14 Sessions	15 Sessions
\$1,050	\$1,050	\$1,050	\$1,125
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

TRANSPORTATION:
 \$40/SESSION _____ SESSIONS
***Please note that there is no transportation available for the Sunday session.**

Additional Information

I warrant and represent that I have no disability, impairment, or ailment that prevents me from engaging in active or passive exercise. This representation is made by me knowing that CityView Racquet Club will rely upon it in allowing me to participate in club activities. Waiver of Claims. I expressly agree that my use of and/or attendance at the Club are undertaken at my sole risk and that the Club's owners, managers, employees and agents (Management) shall not be liable for any damages or injuries to me or my property or be subject to any claim, demand, or cause of action, including for any injury or damage resulting from the negligence of the Club, its management or other club guests. Release of Club. I, on behalf of myself, my executors, administrators, heirs, assigns and successors, do hereby fully and forever release and discharge CityView Racquet Club and its management from all such claims, demands, injuries, actions or causes of action. Consent. I consent to pictures being taken of me by the Club for promotional purposes without the payment of fees or other compensation to me. Minors. Where the participant listed above is a minor (under 18 years old), I, as the minor's parent or legal guardian, expressly make the Health Warranty and agree to the Waiver of Claims, Release of the Club and Consent provisions contained above. I authorize the Club and its Management to obtain medical treatment for my dependent minor.

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

Payment Information

Name on card:		
Credit card number:	Exp. date:	CVV:
Check	Check #:	Amount: