CityView
A Club Above

CITYVIEW SQUASH YOUTH CLINIC APPLICATION – SEMESTER 2, WINTER 2018/19

General Information

Student's Name				
Address				
City		State:		Zip:
Email Address				
Phone Number	Cell Number:			
Date of Birth	Gender: M ◯ F ◯			
School				
Parent/ Guardian				
	Name	**Email**	**Phone**	**Cell 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
13 Sessions	11 Sessions	13 Sessions	12 Sessions
$975	$825	$975	$900
◯	◯	◯	◯

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:	