

**INGLESIDE JUNIOR GOLF CLINIC
2012 REGISTRATION FORM**

NAME: _____ AGE: _____

as of 6/1/12

ADDRESS: _____ Email address: _____

_____ HOME PHONE: _____

GUARDIAN _____ WORK PHONE: _____

June 26-28

July 24-26

July 10-12

August 14-16

CLINIC DATE REQUESTING: 1st _____ 2nd _____ 3rd _____

Shirt size for child? **Adult S, M, L, XL (please circle)** **Childrens S, M, L, XL**

Has child played before? **Yes-No** Parents played before? **Yes-No**

Adult volunteers will be needed for each clinic week. If you or someone you know can volunteer, please leave the volunteer's name and number below.

****ADULT VOLUNTEER**** _____ **PHONE** _____

My son/daughter _____ has my approval to participate in the Ingleside Junior Golf Clinic. It is my understanding that by signing below, I will be responsible for all expenses in the event of any injury to my son/daughter, while participating in the clinic.

PARENT/GUARDIAN SIGNATURE: _____

RELATIONSHIP TO CHILD: _____

PHONE: _____ DATE: _____

EMERGENCY CONTACT: _____ PHONE _____

EMERGENCY CONTACT: _____ PHONE _____

FAMILY PHYSICIAN: _____ PHONE _____

You may register in person or by mail. For the Junior Clinic make checks payable to Tim Kauffman. Our address is 104 Horseshoe Drive, Thorndale, PA 19372. 610-384-9128. All payments must accompany this form and are NON-REFUNDABLE. Please fill out forms thoroughly. All incomplete forms will be returned with payment.

COMMITTEE USE ONLY

FEE RECEIVED ON: _____ **FEE RECEIVED BY:** _____