

CAYS Elite Clinic



Fees - Member - \$30; Non-Member - \$42



First Name _____ Last Name _____

Address _____ City _____ Zip _____

Home Phone _____ Age _____ Sex _____

Parent #1 _____ Email _____

Home Phone _____ Work/Cell Phone _____

Parent #2 _____ Phone _____

Complete if paying via Credit card or using a current billing method on file

____ Use billing method on file Credit Card: ____ Visa ____ MasterCard ____ Discover ____ American Express

Name on Card: _____ Credit Card #: _____

Expiration Date: _____

I authorize the Carlisle Family YMCA to automatically deduct fees due for the above mentioned program per the schedule requested. I understand that it will be my responsibility to notify the YMCA in writing if I wish to change or cancel these automatic payments.

Signature: _____ Print Name: _____ Date: _____

Release Statement & Medical Authorization

I, a parent or guardian of the above named participant, a minor, agree that I and the participant will abide by the rules of the Carlisle Family YMCA, their affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration for the YMCA accepting the participant for its soccer clinic activities, I hereby release, discharge and otherwise indemnify they YMCA, their affiliated organizations and sponsors, their employees, volunteers, and associated personnel including the owners of the gyms and facilities utilized for the programs, against any claim by or on behalf of the participant as a result of the registrant's participation in the programs. Additionally, I give permission for and all medical attention needed by the participant in the event of an accident, injury, sickness, etc., while participating in the program. I also hereby assume the responsibility of paying for such treatment.

Parent or Guardian Signature

Date

Please send registration form in only (second page).