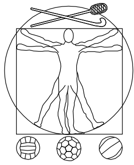
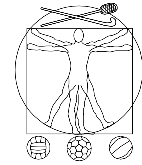


MAD SKILLZ Field Hockey Academy



www.the422sportsplex.com ◆ 1400 Industrial Hwy ◆ Pottstown, PA 19464 ◆ 610.323.9600

Little Skillz
Ages 8 - 12

The Program

Participants in the Little Skillz field hockey clinic will receive 7 weeks of personal instruction. Players will be encouraged to develop their understanding of the game as well as their ability. Our emphasis will be on mastering the fundamentals of field hockey while building confidence in a fun loving environment.

Payment Information

See website for costs. Please return this form along with full payment to hold a spot for your child in your requested class session. Acceptable forms of payment are check, cash, Visa or MasterCard. The 422 SportsPlex has a "No Refund" policy.

Class Schedules

Please check website for dates and times available: We must have a minimum of 10 children to begin a class.

Class Start Date__________________________Day of Week____________________________Time requested___________________________

Player Information

Today's Date____________________________

Participant Name____ ☐Male ☐Female Age__________Birthdate________________

Home Address____Home Phone____

____

Mom Name____Dad Name____

Mom Emergency Number_______________________________________Dad Emergency Number______________________________

Mom Work Phone____Dad Work Phone____________________________________

Mom Email____Dad Email____

In signing this application, I release The 422 SportsPlex, Mad Skillz Field Hockey Academy & other involved parties from any claims or responsibility for injuries suffered in this class/league. I knowingly assume all risks associated with my child's participation, even if arising from negligence of the participants or others, and assume full responsibility for my child's participation. I certify that my child is in good physical condition and can participate in this class/league. Further, I authorize the site director to request medical treatment as necessary to insure my child's well being.

If under the age of 18, a parent or guardian's signature is required. Please print except for signature.

Athlete Name____Signature_______________________________________Date_____________

Parent Name____Signature_______________________________________Date_____________

Health Insurance Provider____Policy #____

Doctor's Name____Phone Number____

Please indicate any medical or special needs that our staff should be aware of.____

____

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Payment Method Used ☐ **Cash** ☐ **Check** (Check #________________) ☐ **Charge** (circle) MasterCard Visa

Credit Card #____Exp______________Code________Amount_______________Initials___