

CONCORD RECREATION DEPARTMENT
90 STOW RD.
CONCORD, MA 01742
978-318-3035

ULTIMATE CLINICS REGISTRATION FORM

Name: _____ Age: _____ M / F Grade fall 04 _____

Address: _____ Phone: _____

Town: _____ State: _____ Zip Code: _____

E-mail: _____

Parent Name(s): _____ Cell/Work Phone: _____

Emergency Contact: _____ Phone: _____

Please indicate the session you will be attending:

____ Session I – Competitive players grades 9+ July 18-22. Tuition: \$250

____ Session II – Beginner/intermediate grades 7+ July 25-29. Tuition: \$175

I am registering:

Solo with 2 or more teammates (\$10 discount)

Amount Enclosed: _____

Please make checks payable to Concord Recreation

I wish to pay in full with a credit card:

Visa MC _____
Credit Card Number Exp. Date: Mo. Yr.

Signature: _____ Date: _____

Allergies, Medications, Health Concerns: _____

I agree to hold harmless the Town of Concord and /or its employees from claims of liability related to any accident that may occur. I give permission for medical treatment to be given to my child if the need arises.

Signature: _____ Date: _____

Please complete form and return (with payment, if applicable) to the address above.