

APPLICATION FORM:

Return to: 12 St. Andrews Crt,
CHIRNSIDE PARK 3116
Phone: 0437 440 310

PUPILS NAME:AGE:

ADDRESS:

TELEPHONE NO: MOBILE:

SIGNATURE:
(Parent/Guardian)

PLEASE CIRCLE SESSION TIME PREFERRED AND STANDARD:

- | | | | |
|--------------------|-----|-----|-----|
| • 9:00 – 11:00 | BEG | INT | ADV |
| • 11:15 – 1:15 | BEG | INT | ADV |
| • 6:30 – 8:30 p.m. | BEG | INT | ADV |

PLEASE INCLUDE A \$10.00 DEPOSIT FEE

TO SECURE YOUR POSITION

MEDICAL DETAILS:

If your child has any allergies or medical condition that the Coach should know, please record details below:

.....
.....
.....

I authorize medical treatment to be sought for my child/children registered above, if deemed necessary by the Coach.

SIGNATURE:

FAMILY DOCTOR:

ADDRESS:

TELEPHONE NO: