

Office Use Only: _____ date received

____ paid ____ email ____ pass ____ c.f



SPORTS PERFORMANCE TRAINING REGISTRATION FORM

Organization

Last Name, First Name

Address - Number/Street/Apartment No

City

State

Zip Code

Date of Birth (MM-DD-YY)

M/F

Evening Phone #

Grade

____ - ____ - ____ ____ _____ - _____ - _____ ____

Email Address

Choose your program:

- Youth Level Training July 18 - 22
- High School Level Training 1wk 3wks 6wks
- College Level Training 1wk 3wks 6wks
- Group/Team Training 1wk 3wks 6wks

Training Days: Monday - Friday
9a-12p @ ESPN Wide World of Sports

Weekly Training Schedule:

- Mar 7-11 Mar 14-18 Mar 21-25 Mar 28- May1
- May 2-6 May 9-13 May 16-20 May 23-27
- May 30-Jun3 Jun 6-10 Jun 13-17 Jun 20-24
- Jun 27-Jul1 Jul 4- 8 July 11-15 July 18-22
- July 25-29 Aug 1-5 Aug 8-12 Aug 15-19
- Aug 22-26 Aug 29-Sep 2 Sept 5-9 Sept 12-16
- Sept 19-23 Sept 26-30

Special Rate, buy two (2) one week sessions,
get the third for free.

Call for Private or Group/Team Rates
407.739.3958

Credit Card:

VISA MasterCard American Express Cash/Check

Credit Card No.

Expiration Date

CVV

(AMEX 4-DIGIT)

____ - ____ _____ _____

Cardholder

Signature: _____

*Billing Address if different from above:

Make Check or Money Order Payable to:

Florida Hospital Celebration Health

Mail all registration forms to:

Florida Hospital Celebration Health
Attn: Sports Medicine
400 Celebration Place
Celebration, FL 34747

Fax: 407-303-4753 Attn: Kevin Costin

ALL FEES ARE NON-REFUNDABLE AND NON-TRANSFERABLE
ALL FORMS MUST BE RETURNED BEFORE PARTICIPATION



MINOR REGISTRATION AND RELEASE FORM

Florida Hospital is organizing a Performance Training Program ("Program") that will be conducted at **ESPN's Wide World of Sports complex** from _____ at 9:00a.m.until _____, 2011 at 12:00p.m. All minors over the age of 6 are eligible to participate upon receipt of consent of the minor's parents.

In order to participate, the Registration and Release Form (the "Form") will need to be completed and returned one week before attending the Program to Kevin Costin at Florida Hospital Celebration Health.

REGISTRATION:

Last Name: _____ First Name: _____
Address: _____
City: _____ Zip Code: _____
Sex: _____ Age: _____ Date of Last Medical Exam: _____

Legal Name of Mother: _____
Legal Name of Father: _____

RELEASE:

In consideration of my minor child being permitted to participate in the aforementioned Program, we hereby agree to release Florida Hospital ("Hospital"), its agents, officers, directors and employees from any and all liability, claims, demands, or causes of action whatsoever (including any liability, claim, demand or cause of action that is attributable in whole or in part to the negligence of the Hospital or its officers, directors, employees or agents) arising out of or related to any loss, damage, or injury, including death, that may be sustained by my minor child, or any property of my minor child while participating in or waiting to participate in Program activities. We further agree to indemnify, hold harmless, and defend the Hospital and its officers, employees, directors and agents against all claims, suits, losses, damages and costs, including but not limited to court costs, and reasonable attorney's fees on account of any injury (including death) of my minor child or any property of my minor child arising out of his/her participation in the Program.

This release shall be binding on our respective heirs, next-of-kin, executors, administrators and/or personal representatives and my minor child, including his/her next-of-kin, executors, administrators and/or personal representatives.

For Each Parent identified above:

Date: _____ Signature: _____

Date: _____ Signature: _____

Emergency Contact Name: _____

Emergency Contact Number: _____