



NAT March Break Camp-2019 Registration

March 11th-15th 2019

Player Name: _____

Birthdate: _____

Age: _____

Parents' Names: _____

Phone Number: _____

Email: _____

Address: _____

City: _____

Postal Code: _____

Emergency contact: _____

Phone: _____

Relationship to the player: _____

Please select either full day or half day.
 If you have selected half day please check either morning or
 afternoon.

	Monday	Tuesday	Wednesday	Thursday	Friday	Comments
\$50.00 Full day						
\$30.00 Half day						
9 am-12 pm						
1-4 pm						

Home-Stay Needed? 187.50 per week
 Insurance Needed? \$25 per week

Total fees: _____

Tax at 13%: _____

Total fee payable _____

Method of Payment

Cheque

Credit

Debit

Cash Date:

Staff Signature:

Release, Warrant and Indemnity:

By completing this form and in consideration of the acceptance of the application for enrolment of the participant named above in the Niagara Academy of Sports program identified above. I for myself and (if applicable) on behalf of the participant (if the participant is a minor) and our respective heirs; executors, administrators, and assigns, hereby RELEASE, WAIVE, AND FOREVER DISCHARGE Niagara Academy of Sports, and its agents, servants, contractors, representatives, successors and assigns (Releases) of and from all claims, demands, and damages, costs, expenses, actions and cases of actions whether in law or equity, in respect of death, injury, loss or damage to my person or property or to the Participant howsoever caused, arising or to arise by reason of the participation in the Niagara Academy of Sports program whether as a spectator, participant, competition, or otherwise and whether prior to, during or subsequent to any classes in the respect thereof and notwithstanding that same may have been contributed to or occasioned by the negligence of the aforesaid. I further undertake to hold and save harmless and agree to indemnify the Releases from and against any and all liability incurred by any or all of them arising as a result of or in any way connected to the participation of the participant I the Niagara Academy of Sports program. I hereby authorize the Niagara Academy of Sports to display my personal information within the Niagara Academy of Sports so that other members/players may contact me for the purpose of scheduling.

Parent/Guardian Signature

Date

Payment Terms:

- We accept cash, debit, cheque, credit card (payable to Niagara Academy of Tennis).
- There are absolutely NO refunds unless for medical reasons or deemed appropriate by Niagara Academy of Tennis.
- If you have any questions regarding payments and/or billing please call 905.562.0683, Monday to Friday, 10am – 4pm. And ask for Rina Bergshoeffe) info@niagaraacademy.ca

I, the undersigned, have read and agree to the Niagara Academy of Tennis payment terms and policies:

Parent/Guardian Signature:

Date:

Consent to Photograph and Record:

Many opportunities are presented throughout the camp to share positive stories about what is going on in Niagara Academy. Media contact could be initiated by us through a News Release that highlights a special activity or event; or contact may be initiated by the media with respect to an educational issue or initiative for which they are seeking local information. We seek every possible opportunity to present positive stories to our community.

This "Consent to Photograph and Record" form is seeking your authorization for your child's recorded image, voice or work to

be used by the media or in Academy publications, presentations and on websites over the year as opportunities arise.

Your completion of this form is sincerely appreciated. Should you have any concerns with respect to providing this permission for your child; please contact Niagara Academy.

I hereby give my permission for my child's recorded image (whether it is still or video), voice or work to be used by the media or in Academy publications, websites and presentations. I understand that I/my child may be identified by name.

YES: _____ NO: _____

Parent/Guardian Signature: _____ **Date:** _____

Credit Card Authorization

I, _____ authorize Niagara Academy to charge the following payments to the Credit card specified below beginning _____ and ending _____

Total amount authorized: _____

- Card Type: _____
- Name on Card: _____
- Expiry Date: _____
- Credit Card #: _____ V- Code: _____

This understanding is entered into by:

- Parents' Name: _____
- Address: _____
- Telephone #: _____

Acknowledged and signed by:

Parent Signature: _____ Date: _____

Medical form

Please complete the entire form. It is important to ensure proper medical care. When older participants are seen for minor illnesses or injuries, they are encouraged to inform their parents themselves. However, with younger participants in almost every instance or with older participants with more serious problems, the physician or staff member will try to contact the parents to inform them of the problem and discuss treatment. Occasionally, we are unable to reach parents immediately. The parent's signature on the medical treatment authorization below allows treatment in these circumstances.

Program (s) attending _____

I. Personal information

Name: Last: _____ First: _____ Middle: _____

Date of Birth: DD _____ MMM _____ YYYY _____

Age: _____

Sex: Male Female

Home Address (include postal code or zip)

Home phone: () _____ Parent Cell phone: ()

In case of emergency notify: (name of parent or contact) (relationship)

Home phone: () _____ Cell phone: (____) _____ Office phone: (____)

Alternate Contact Information: (name/relationship)

Health Card Number: _____

Family Physician: _____ Phone: (_____) _____

II. Background

Please provide any pertinent information regarding your child's current health, past medical history, and/or medications taken, that may help us better coach/teach your child and which can assist medical staff should an emergency occur.

Please list any medications being taken and include dose & frequency.

Have you ever had any of the following: (please check)

Allergies: _____

Asthma Epilepsy Diabetes Bleeding disorder Heart condition

III. Insurance information

Outside of Canada: – Please provide Primary Medical Insurance / Dental Insurance Information in the space below

Medical treatment authorization and liability release

I, the undersigned acknowledge that I am the parent or guardian of, and do hereby grant my permission for him/her to participate in the Niagara Academy of Tennis Inc. programs, and to actively and fully participate in all activities thereof. In the event of an injury or illness during these activities, my signature indicates that I agree to allow medical treatment even if I cannot be contacted, and authorize Niagara Academy of Tennis Inc. and/or the local hospital to provide the needed medical treatment they deem necessary. I hereby release Niagara Academy of Tennis Inc. and all members of the program's staff, the host facility and its staff, the local hospital and their doctors, agents, employees, and representatives, and all officers of Niagara Academy of Tennis Inc. from any and all claims and liability arising in any way out of its exercise of this authority. I understand and agree that all bills for any medical/dental care and treatment will be forwarded to the undersigned and/or insurance company, and that it will be my responsibility to see that such bills are paid. I further acknowledge, understand, and agree that in participating in this activity there is a possibility of physical illness or injury and that I, as parent or guardian of the participant, am assuming the risk of such injury by his/her participation and release Niagara Academy of Tennis Inc, the program's staff, the host site and it's staff, and all affiliated with or participating in the Niagara Academy of Tennis Inc, from all liability, claims, obligations or responsibility for personal property losses, accidents or injuries of any kind. I understand the inherent risks of the training process for an athlete and recognize that the program is strenuous. I understand the activities that are carried out during the program. I further authorize the program staff to administer non-prescription analgesics for minor medical problems such as headaches, etc. unless I have requested otherwise.

Parent / Guardian Signature and relationship Player's signature (if over 18 years of age)

Date: _____