INFLUENCING THE NEXT GENERATION INFLUENCING THE NEXT GENERATION

Clinic Director Coach Richard Hill 45 Rt. 88 South, Newark, NY 14513

" 8th ANNUAL I'M POSSIBLE" PRESIDENT'S DAYS BASKETBALL CLINIC
WITH NBA SKILLS COACH- BRYCE STANHOPE

Who: Boys and Girls: Ages 10U – 16U
What: Basketball Skills Clinic
When: February 19th – 23rd 2018

Where: New York Chiropractic College, Seneca Falls, NY
Time: 9 am to 4 pm Daily
Cost: $165.00 by February 16th, 2018

Players Name:		**MALE FEMALE**
Address:	**City:**	
State: **Zip:**	**Phone #:**	
E-mail Address:	**Work #:**	
Parents Name:	**Cell #:**	
Birth date: **Grade:**	**(based on 2017 – 18 academic year)**	

PLAYER INFORMATION

Position:	**Height:**	**Are You Interested in SPRING Basketball:**

Shirt Size: YS M L XL Athlete's Skill Level : Beginner/ Intermediate/ Advanced

CLINIC PURPOSE: The purpose of our Clinic is to teach sound fundamentals to each player regardless of their skill Level of ability.

REASONS TO ATTEND: Quality over Quantity, Well Organized, Trainer on site for Players, 1 Staff for every 9 players, Excellent Facilities, Clinic Shirt included in Fee, We stress Fundamentals, and They'll have FUN.

PAYMENT PAYABLE TO: Central Western AAU, 45 Rt. 88 South, Newark, NY 14513

1. Check # Amount-
2. You may also pay Online for this Clinic at : www.centralwestern.org
3. (Cash or Money orders only at the door) If we have room for the Player.

FOR MORE INFO on this Clinic CONTACT Richard Hill 585-261-2514 or rhill75068@aol.com

This is a contract between Central Western NY Youth Basketball Clubs Inc. and the responsible paying party. You are under contract to pay in full. There will be no refunds after you sign up for the clinic or choose to leave the clinic early. Refunds given only if you are injured before the clinic begins and submits a doctor's written excuse.

RULES: Each participant will be expected to adhere to all clinic rules and regulations, or they will be dismissed from the clinic.
INSURANCE: Medical Coverage for this Clinic is Secondary Insurance and the Participant must be covered by the Family's Insurance to participate in this clinic.

Parents Signature____+ **Date**_______________

Athletes Signature ____

In case of injury to my child, I grant permission on our family's behalf in case of emergency that the clinic should get medical assistance if necessary. We certify that he/she is physically fit for the clinic according to our family physician. We are also aware that the clinic's medical coverage is Secondary Insurance and have adequate family insurance coverage for them to participate. The undersigned releases the Clinic and College from any liability.

INSURANCE COMPANY: ________________________ POLICY#________________________

PARENT OR GUARDIAN ________________________ DATE:________________________