

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
- 6:00 – 8:00 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: _____