Springfield Curling Club

Monday Junior Curling League

Name:_____

Address:_____

Medical Numbers: (6 digit family #)_____

(9 digit personal #)_____

Date of birth:_____ Phone #:_____

Email address:_____

Number of Years of Curling:____ Positions Previously Played:_____

Position Preferred for this year:_____

Person to contact in case of emergency

Name:_____ Relationship:_____

Phone#_____Work#_____Cell:_____

Special Medical needs_____

Waiver & Consent in case of an emergency

I hereby authorize emergency medical or surgical treatment for my son/daughter/ward is such treatment is needed before, during or after the Springfield Curling Club Teen Curling Program.

I hereby release all persons involved in the organization of and the running of the Springfield Curling Club Teen Curling Program from any claims, actions, demands or damages of any nature or kind whatsoever that my son/daughter/ward and his/her equipment may incur before, during or after the Springfield Curling Program.

Signature of Parent_____Date:_____

Signature of Teen Curler_____