



Marianjoy's 2011 Golf Clinics for Kids!

REGISTRATION FORM

PLEASE NOTE: A completed Registration Form and Signed Physician Release are required for each golfer.

Child's Name: _____ Child's Age: _____

Address: _____

City/State/Zip _____

Phone Number: _____ E-Mail _____

Please describe your child's physical disability: _____

Emergency contact with phone number: _____

CLINIC DATES All clinics are held on Thursdays, from 6:00 p.m. – 7:15 p.m.

I would like to register my child for all 5 clinics for \$70.00 (includes August 11th Grand Finale Course Event)

I would like to register my child for the following clinics at \$15.00 per clinic:

- June 9**, **July 7**, **August 4** Cantigny Golf Club, Wheaton
- June 23**, **July 21** Oak Meadows Golf Club, Addison
- August 11th Grand Finale Course Event** Cantigny's Youth Links, Wheaton
(Child must have attended 3 clinics to be eligible to participate in this event)

Will your child need clubs? No Yes (Circle one): Right-handed Left-handed Child's height _____

Is your child able to stand independently? Yes No

If no, please describe assistance needed: _____

Will golfer be playing at wheelchair level? Yes No

Is your child able to use both arms? Yes No (Circle stronger side): Right Left

Does your child have dietary restrictions/allergies? _____

Does your child have previous golf experience? _____

To help us make this a positive and beneficial experience for your child, please include an other information/comments you feel would be important for us to know about him/her:

REGISTRATION QUESTIONS? PHONE (630) 909-6010 OR VISIT www.Marianjoy.org

MAIL REGISTRATION: Mail signed physician release and completed registration form with check to:

Marianjoy Rehabilitation Hospital • 26W171 Roosevelt Road • Wheaton, IL 60187 • Attn: Tracy Ekstrom

Check enclosed payable to "MARIANJOY REHABILITATION HOSPITAL"

Please charge my credit card: Visa Mastercard Amex Discover

Account Number _____ Exp. Date _____

Name on Card _____ Signature _____

FAX REGISTRATION FORM (FRONT AND BACK SIDES) AND PHYSICIAN'S RELEASE TO: (630) 909-8411

COMPLETE ADDITIONAL RELEASE INFORMATION ON THE BACK SIDE OF THIS FORM



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ADDITIONAL RELEASES

I hereby grant permission for my child's photo to be taken and used for publicity purposes related to Marianjoy.

Parent/Guardian's Signature _____ Date _____

I do hereby authorize the associates of Marianjoy to act for my child according to their best judgment and ability. I release and will not hold Marianjoy or any of their associates or agents responsible for any liability arising from participation in their programs or outings. I understand that Marianjoy does not carry medical insurance for participants.

Parent/Guardian's Signature _____ Date _____