



# Limestone Girls Club Fliptastic Gymnastics

## Summer 2010 Tumbling & Cheer Clinic Registration

Clinic Dates: June 22, July 22, & August 2

Clinic Times: 8:30AM-12:30PM (snack provided)

### Payment and Fee Information:

**\*\$50 per student per clinic or \$130 per student for all three clinic dates if paid in full at June 22 clinic. All students must have a current 2010 annual membership. Membership fees are \$25 per calendar year, or one time Event Memberships are available for \$10 and are valid only for one clinic date. Annual membership privileges do not apply with Event Membership. \*Registration fee includes Camp T-shirt (limit one per student)**

### Please check clinic date(s) student is registering for:

\_\_\_ Tuesday, June 22 8:30am-12:30pm

\_\_\_ Tuesday, July 22 8:30am-12:30pm

\_\_\_ Tuesday, August 2 8:30am-12:30pm

Registration begins at 8:00AM each clinic date. Pre-registrations are welcome and encouraged.

Pre-registrations may be placed in drop box at front doors or mailed with payment to:

**Limestone Girls Club  
Attn: Gymnastics/Cheer Clinic  
2009 19th Street  
Bedford, IN 47421**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Age \_\_\_\_\_

Birth date \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Grade \_\_\_\_ Parent's Names \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_ - \_\_\_\_ Cell Phone Number \_\_\_\_ - \_\_\_\_

Email \_\_\_\_\_ Circle Shirt Size : ys ym yl xl AS AM AL

Medical Condition or Allergies \_\_\_\_\_ **Registrations are not taken by phone**

I \_\_\_\_\_, the parent/legal guardian of above registered student understand that as with any athletic program there are certain risks of injury. I understand the Girls Club will take every precaution and provide safe facilities and instructors for my child and will hold blameless the Limestone Girls Club, any employee or instructor of this program in the unlikely event that my child is injured.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Office Use Only** \$25 2010 Membership Fee Paid \_\_\_\_\_ \$50 Clinic Fee Paid \_\_\_\_\_ \$130 3 Clinic Fee Paid \_\_\_\_\_

Receipt # \_\_\_\_\_ Check Number \_\_\_\_\_ Cash \_\_\_\_\_ Credit Card Type \_\_\_\_\_

Staff Initials \_\_\_\_\_