



Improvement happens in the off season

www.renegadesbasketball.com

Email: parenegades@comcast.net

Phone: 215-919-0019

Renegade Member Cost: 4 Sessions - \$140.00

Non-Renegades Cost: 4 Sessions - \$180.00

## Individual or Group Training Permission Form

Player's Name: \_\_\_\_\_

If non-Renegade and play with another club, provide AAU insurance card number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Home Phone# \_\_\_\_\_

Mom's Name: \_\_\_\_\_ Dad's Name: \_\_\_\_\_

Mom's Cell # \_\_\_\_\_ Dad's Cell # \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Experience Level \_\_\_\_\_

Individual or Group training? \_\_\_\_\_

Check Payable to: Renegades Basketball, [or Cash]

\_\_\_\_\_ has my permission to participate in the Renegades' Individual training sessions. I hereby assume all risks associated with the participation of my child in this program and agree to hold harmless the Renegades, Inc. organization, their officers, coaches, and participants for any and all claims for injuries arising out of the participation in this program. All participants are required to be covered by a personal or family medical plan including hospitalization before they can participate in the program. I certify that my child is covered by such a plan. I, the undersigned do hereby grant permission to any licensed physician to perform or provide necessary medical care or aid to my child in the event that he/she is injured while playing basketball in this program. I understand the details of this form and attest to its accuracy.

(Date) \_\_\_\_\_ (Parent/Guardian Signature) \_\_\_\_\_