

CTF Fencing Program Registration & Health Form

8-Week Beginner I Foil Class

Mondays or Thursdays (TBD) from 4:00 pm to 5:00 pm

January 28<sup>th</sup> to March 18<sup>th</sup>

Cost is \$160.00 (includes electric equipment rental)

A USFA non-competitive membership (minimum) for the 2018-2019 season is required (\$10 for the year). This membership can be upgraded to competitive for an additional fee. Go to usfencing.org website <http://www.usfencing.org/page/show/698114-membership> and follow the instructions.

USE CONNECTICUT FENCERS CLUB TO SIGN UP FOR YOUR USFA MEMBERSHIP

Total Amount Payable by 1/28/2019 \$ 160.00

Student's Information

USFA membership number: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Fencer, Parent or Legal Guardian Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Fencer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ phone: \_\_\_\_\_ email: \_\_\_\_\_

Family Doctor's Name:

Doctor's Address:

Doctor's Phone:

Please read each statement below and if you understand and agree to each statement **WRITE YOUR INITIALS** in the space next to the paragraph to signify your understanding and agreement.

In the event I/ my child needs emergency hospital or medical care while participating in the Beginner Foil Program my hospital preference is:

Hospital Name and Address

However, if circumstances are such that it is deemed necessary to admit elsewhere, permission is hereby granted.

In the event I/my child needs emergency medical care while in this program, I hereby give permission for the medical staff to give such emergency treatment as is considered necessary or desirable by medical judgment, including administration of anesthesia.

In the event that I/my child needs to be transported by an ambulance, I give my permission for such transportation and I agree to assume all expenses incurred by said transportation.

I agree to assume all medical expenses incurred by myself/my child while participating in this Beginner Foil Program.

I realize that as with any physical activity there is a possible risk of accidental injury to myself/my child while participating in this Beginner Foil Program. I agree to assume the risk of any injury, which I/my child might suffer while involved in the Beginner Foil Program and will not hold Jennette S. Faulkner or the New Britain Quartette Club liable for any injuries, which I/ my child may suffer, while participating in this Beginner Foil Program.

Signature of Student \_\_\_\_\_

Date \_\_\_\_\_

Signature of Parent/Legal Guardian if Student is under 18 \_\_\_\_\_

Date \_\_\_\_\_

PLEASE COMPLETE THIS FORM AND RETURN TO COACH STARKS-FAULKNER AT [Jsfaulk1@sbcglobal.net](mailto:Jsfaulk1@sbcglobal.net) BY JANUARY 18<sup>TH</sup>, 2019