8 Riverside Street Nashua, NH 03062
(603) 595-2400 Fax (603) 595-9406
www.conwayarena.com

WEEKLY SKILLS CLINIC SPRING 2008
April 16th- June 18th

PLEASE PRINT CLEARLY

PARTICIPANT: _____

PARENT/GUARIDIAN: _____

PARTICIPANTS DOB:_____ AGE: _____

MAILING ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE: ( )_____ EMERGENCY PHONE: ( )_____

E-MAIL ADDRESS:_____

CIRCLE LEVEL: **CIRCLE TIER** (IN GSHL)

MITE SQUIRT PEE WEE BANTAM 1 2 3 4

Enclosed is: ° Weekly Skills $100 deposit

° Weekly Skills Program Fee- $199

Checks can be made payable to Conway Arena

Visa and Mastercard accepted. #_____ Exp Date_____

NOTE: NEITHER THE CONWAY ARENA, STAFF OR VOLUNTEERS ARE RESPONSIBLE FOR ITEMS LOST, STOLEN OR MISPLACED

I, the parent/guardian of the above named boy/girl give my approval for his/her participation in the CONWAY ARENA programs. I do hereby release, absolve, and hold harmless the CONWAY ARENA, its directors, staff, organizers, sponsors, coaches, volunteers and anyone connected with the programs. In the case of injury, I hereby waive all claims against the aforementioned persons. I have read and understand all the above information. I will abide by the policies set forth by the CONWAY ARENA.

PAYMENT/REFUND POLICY: Enrollment is based on a first come, first serve. A 50% deposit is due at time of enrollment if the program exceeds $100. Otherwise, payment is required in full. All deposits/payments are non-refundable unless the program is cancelled or authorized by a program director.

SIGNATURE: _____ TODAY'S DATE:_____

OFFICE USE ONLY: AMT. PAID$_____ CASH_____ CHECK #_____

CC#_____ CC EXP._____

CC NAME_____ BALANCE DUE_____

BALANCE DUE DATE_____ ENTERED_____ CRS INITIALS__