PLEASE COMPLETE THE FOLLOWING INFORMATION TO COMPLETE REGISTRATION.

Athlete Information:

Name: _____ DOB: _____ Grade: _____ Shirt Size: _____

Sport: _____ Position: _____

Parent Information:

Parent First/Last Name: _____ Parent First/Last Name: _____

Email: _____ Email: _____

Phone: _____ Phone: _____

Address: _____ City: _____ Zip: _____

PLEASE LIST ANY PAST INJURIES YOU FEEL WE SHOULD KNOW ABOUT AS YOUR TRAINERS:

PACKAGE AND PAYMENT INFORMATION:

Sessions Purchased: Patriot High School Baseball and Softball Training

Dates: Nov 2014- Feb 2015 Frequency: 3x/week supervised Days: Monday, Wednesday, Friday

Sessions: 36 Session Time: 60-75min depending on number of participants Time: 5:00-6:30

Cost: $630.00 ($17.50 per session for 36 sessions)

PAYMENT METHOD

ONLINE REGISTRATION AVAILABLE AT WWW.ATHLETESADDICTION.COM STARTING 11/14/14

IF PAYING IN FULL PLEASE COMPLETE THE FOLLOWING:

Cash Amount: _____ Check # and Amount: _____

Credit Card Type: _____

Name As It Appears On Card: _____

Card Number _____

Exp Date _____ Billing Zip Code _____

IF PAYING IN 3 MONTHLY INSTALLMENTS, PLEASE COMPLETE THE FOLLOWING:

Recurring Payment Authorization Form

Schedule your payment to be automatically deducted from your bank account, or charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I _____ authorize Athlete's Addiction to charge my credit card
(Full name)

indicated below for $210.00 on the 21st of each month for 3 consecutive months for payment of my

Patriot High School Baseball/Softball Training Sessions. The total amount charged, after the third and final payment,

will be equal to $630.00.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Checking/ Savings Account

☐ Checking ☐ Savings

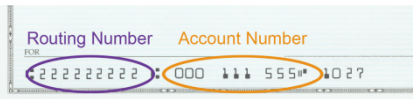
Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____



Credit Card

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

CVV (3 digit number on back of card) _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Athlete's Addiction in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Athlete's Addiction may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25.00 charge for each attempt returned NSF, which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

ATHLETE'S
ADDICTION

PHOTO WAIVER:

At Athlete's Addiction we like to capture photos or videos as part of our instructional program, as well as a way to share these activities with our community. We need your permission to photograph your child for use on our company's media outlets. We will never use names, addresses or any other personal information in these publications. By signing below you give Athlete's Addiction staff permission to photograph/video your child and use in our company's media outlets. (A separate form must be completed for each child attending Athlete's Addiction Programs) **If you choose not to sign this form, we will not use your child's photograph/video in publications.

____ You have my permission to photograph my child.

Parent/Guardian Signature: _____ Date: _____

ATHLETE'S
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Medical Treatment Authorization Form

This form grants temporary authority to Athlete's Addiction to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them.

Minor

Full Legal Name: _____

Home Address: _____

Date of Birth:_____ Gender: Female _____Male_____

Information for Medical Treatment

Physician's Name and Location of Practice: _____

_____

Physician's Phone # (if known): (____)_____

Medical Insurer/Health Plan: _____ Policy #: _____

Allergies to Medications: _____

Allergies (Other): _____

Please note **all** conditions for which the child is currently receiving treatment:

_____

Note any other significant medical information:

_____

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for Athlete's Addiction Staff (hereafter "Designated Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective through April 15, 2014

Signed this _____day of_____, 20__.

Parent / Legal Guardian Signature: Printed Name:

Health Questionnaire

**** If for a minor, to be completed by a Parent/Guardian of Child**

Name of Participant: _____ DOB:_____
Emergency Contact Name & Number _____
As you are to be a participant in these workout sessions, please complete the following physical activity readiness questionnaire.

	YES	NO
1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?	_____	_____
2. Do you ever experience chest pain during physical activity?	_____	_____
3. Do you ever lose balance because of dizziness or do you ever lose consciousness?	_____	_____
4. Do you have a bone or joint problem that could be made worse by a change in your physical activity participation?	_____	_____
5. Do you have uncontrolled asthma (i.e. asthma that is not easily controlled by an inhaler)?	_____	_____
6. Is your doctor currently prescribing any medication for your blood pressure or heart condition?	_____	_____
7. Do you know of any other reasons why you should not undergo physical activity? This might include diabetes, a recent injury or serious illness.	_____	_____

I _____ declare that the above is information is correct at the time of completing this questionnaire on:
(Date) _____/_____/_____ Signature: _____

If you answered YES to one or more questions, please complete the following:

- ☐ Talk to your doctor in person discussing with him/her those questions you answered yes.
- ☐ Ask your doctor if you are able to participate in the physical activity requirements of these workout sessions. If medical clearance is granted please have your doctor complete the following:

_____ is able to participate in the physical activity requirements of the workout sessions with Athlete's Addiction and their trainers.

Doctor's Name _____
Doctor's Signature _____ Date: ___/___/___
***If your health changes during the course of these training sessions, please inform the trainers and consult with your doctor.*