The Colts Neck Golf Club
The New Jersey Golf Performance Academy
2020 Junior Golf Registration Form

(Circle Program)

Clinic I: *April 6th-April 29th ($275)* **Clinic II**: *May 4th-May 27th ($275)* **Clinic III**: *June 3rd-June 29th ($275)*
Fall Clinics: *Sep 14th-Oct 7th ($275)* **Day pricing available for clinics ONLY**
Half-Day Camp: *June 22-26 ($300)* **5-Day Summer Camp:** *($550)*
Week 1: *6/29 - 7/3* **Week 2:** *7/6 - 7/10* **Week 3:** *7/13 - 7/17* **Week 4:** *7/20 - 7/24*
Week 5: *No Camp* **Week 6:** *8/3 - 8/7* **Week 7:** *8/10 - 8/14* **Week 8:** *8/17 - 8/21*

Student Name(s): _____ Member No. *(if applicable)* _____

Age(s): _____ Date(s) of Birth: _____

Name of Parent/Guardian _____ EMAIL: _____

Address: _____

Telephone 1: _____ Telephone 2: _____

EMAIL: _____

Emergency Contact Numbers: _____

Is there any specific information or instructions we need to know regarding your child / children?

_____

***INDEMNIFICATION**: I agree to allow my child / children to participate in any activity sponsored by the New Jersey Golf Performance Academy at The Colts Neck Golf Club in the above program. I agree to assume all risk and hazards incidental to such participation and release, absolve, and indemnify any claim arising out of injury to my child / children. I also agree to return all equipment issued to my child / children in good condition, except for normal wear and tear, or pay the current replacement costs.*

MEDICAL RELEASE CONSENT AND MEDICAL INSURANCE INFORMATION

I hereby certify that my child/children is/are in good health, has/have had a recent physical and may participate in activities at The Colts Neck Golf Club. In the event of an emergency, I give my permission to my child / children's instructor for my child / children to be given treatment at a local hospital.

_____
Signature of Parent or Guardian

INSURANCE COMPANY:	PHYSICIAN:
ID NUMBER:	PHYSICIAN PHONE:

Weekly reservations must be made 10 days in advance with payment and complete registration or a $50.00 late registration fee will be applied.

Total amount enclosed: _____ Please charge my account *(please check if applicable)* _____

Credit Card # _____ Expiration_____ CVV_____ Zip Code_____

Name On Card _____

Parent/Guardian Signature _____ Date _____

OVER→

50 Flock Road • Colts Neck • NJ • 07722 • Tel: 732-303-9330 • Fax: 732-625-7952 www.coltsneckgolfclub.com

IF PARTICAPATING IN CLINICS
PLEASE CIRCLE THE CLINIC AND PUT AN "X" ON THE DATES
YOU WILL <u>NOT</u> BE PARTICAPATING IN.

Clinic I	4/6	4/8	4/13	4/15	4/20	4/22	4/27	4/29
Clinic II	5/4	5/6	5/11	5/13	5/18	5/20	5/25	5/27
Clinic III	6/3	6/8	6/10	6/15	6/17	6/22	6/24	6/29
Fall Clinic	9/14	9/16	9/21	9/23	9/28	9/30	10/5	10/7