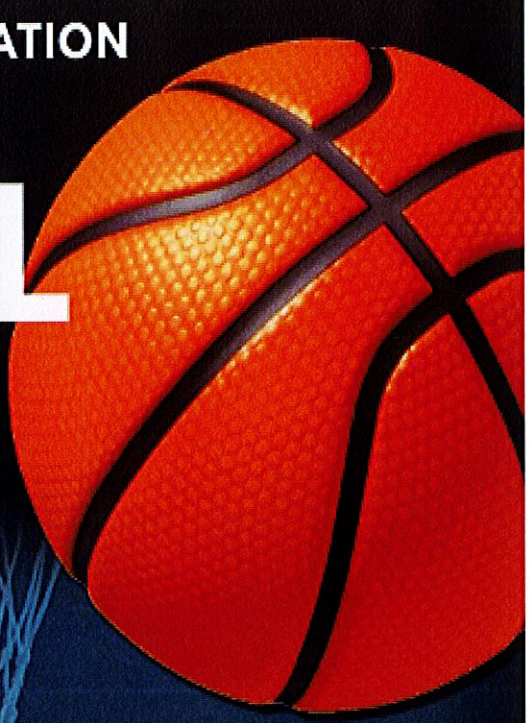
TOWN OF CLINTON RECREATION

BASKETBALL CLINIC



at Cory's Court Fran Mark Rec Park

Coach: Dan Harkenrider with 16 years of experience coaching AAU girls basketball

Four Tuesdays in August

Aug. 2, 9, 16, 23

CO-ED: Boys and Girls entering Grades 2 - 5

August 2, 9, 16, 23

6:30 - 8 PM

Cory's Court

at

Fran Mark Rec Park

$50 / child

REGISTRATION REQUIRED:
Forms are found at:
townofclinton.com

Forms returned to:
Cathy Gallinger
Town of Clinton
1215 Centre Rd.
Rhinebeck, NY 12572

For more info:
dan@townofclinton.com

SKILLS: dribbling shooting defense 3 V 3

Every camper will receive a T shirt and basketball

Town of Clinton Recreation

2022 BASKETBALL CLINICS

REGISTRATION FORM

Child's Name: _____ Date of Birth: ___/___/___

Parent Name: _____

Address: _____

City, State & Zip: _____

Phone number: _____/_____/_____

Emergency contact call phone number: _____

Child's Grade for 2022-2023 school year: _____

Child's T - shirt size: _____

Clinton Rec Basketball Clinics

Cory's Court at Fran Mark Rec Park

CO-ED, boys and girls entering grades 2 - 5

August 2, 9, 16, 23

6:30 PM - 8 PM

$50 / child

Each child will receive a basketball and T - shirt.

Coach: Dan Harkenrider: 16 years of experience coaching AAU girls basketball

Skills: Practice dribbling, shooting, defense, 3v3

The Town of Clinton Medical Form must be submitted with the registration form along with the fee to confirm attendance. The medical form is attached.

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Parent/Gaurdian Signature _____ Date: ___/___/____

Payment date: ___/____/____ cash or check # _____

Registration forms and fee returned to:
Cathy Gallinger, Supervisor's Secretary

Town of Clinton, 1215 Centre Rd. Rhinebeck NY 12572

2022 BASKETBALL CLINICS
MEDICAL FORM

This form must accompany the Registration Form

IMMUNIZATION RECORD NEEDS TO BE ATTACHED TO EACH CAMPER'S REGISTRATION FORM –
Parent or Legal Guardian Must Initial Here _____

EMERGENCY CONTACTS It is necessary that we have **TWO** persons to call that are available during the 6:30 – 8 PM sessions.

Name: _____ Phone:_____

Name: _____ Phone:_____

If your child has any special needs or special requirements please list here:

_____

If there is an existing Order of Protection, Custody Order or other Court Order pertaining to the custody of your child please indicate below and submit a copy of such Order with this application:

_____

MEDICAL QUESTIONS

1. Does your child have a vision, hearing, or other physical disability which requires special attention or would limit participation in this clinic? ___ Yes ___ No

If yes, explain: _____

_____

2. Does your child require emergency treatment for epilepsy, diabetes, nose bleeds, bee stings, etc. ___ Yes ___ No

If yes, explain: _____

_____

3. Does your child have allergies ____ Yes ___ No

If yes, explain: _____

_____

In the space below, please list any additional information you wish we should be aware of:

_____

_____

_____

Parent or Legal Guardian signature _____

Date_____