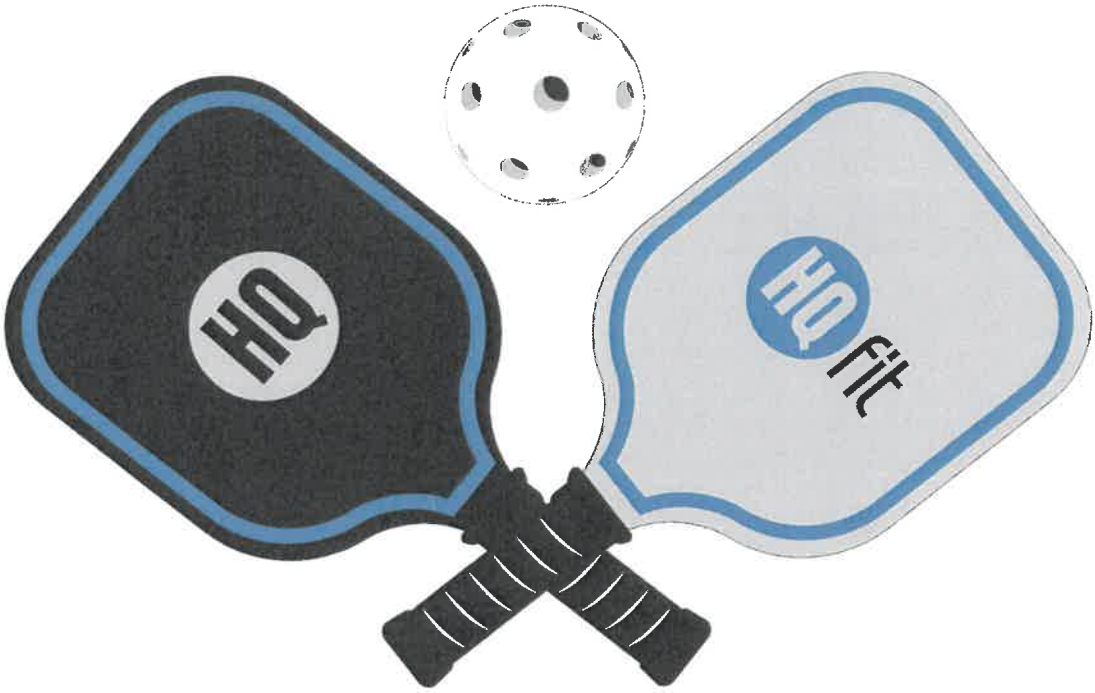
# KIDS PICKLEBALL

HQ fit

**HealthQuest Fitness Club**
310 Hwy 31N • Flemington, NJ • hqfit.com




**Ages:** Boys and Girls ages 7-12
**Days:** Wednesday 6:15 -7:00
**Dates:** April 24th -May 22nd
**Price:** $100

**Learn the game and play real matches! We will provide all equipment.**
**LIMITED SPACE**

For more info, call 908.782.4009, ext. 234 or email bunnell@hqfit.com

# Kids Pickleball

**Participant's Name:** _____ **Date of Birth:** _____/_____/_____

**Address:** _____ **City**_____ **State**_____ **Zip**_____

**Home Phone #:** _____ **Email Address:** _____

**Emergency Contact:** _____**Cell Phone #:** _____

## Boys & Girls $100 per player

## Dates April 24th – May 22nd 2024

## Ages 7-12 Wednesday 6:15-7:00pm

**Total:** _____

**No Refunds Once Registration is Processed**

**Cancellation Policy:** There is a $25.00 cancellation fee once the enrollment form is received unless the program is cancelled by HealthQuest. No cancellations will be accepted after the program begins. Credit requests due to injury or extended illness must be evidenced by a doctor's note. All credit requests must be made within 7 days of the injury or illness.

## RELEASE STATEMENT:

I, the parent/guardian of the registrant, a minor, or an adult registrant of legal age, agree that the registrant and I will abide by the rules of HealthQuest of Central Jersey, LLC., its affiliated organization and sponsors. Recognizing the possibility of physical injury associated with leagues and in consideration for HealthQuest of Central Jersey, LLC. accepting the registrant for its league programs and activities, I hereby release, discharge, and/or otherwise indemnify HealthQuest of Central Jersey, LLC., its officers, coaches, managers, referees, its affiliated organizations and sponsors, their employees, and associated personnel, including the owners of the fields and facilities utilized for the league program, against any claim by or on behalf of the registrant as a result of the registrant's actions. I affirm that the registrant is in sound physical and healthy condition and that the athlete is covered by health/accident insurance secured independently. As parent/guardian or the registrant, I hereby give my permission for the participant of the program to be transported for emergency medical care. I hereby authorize consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions necessary to preserve life, limb or well being of my dependent.

**Signature of Parent/Guardian :**_____

**Method of Payment**
**(PLEASE CIRCLE)**

**Cash** **Check** **Credit Card** **Member Charge (CC on File)**

**Account Number** _____ **Expiration Date:** _____

**Signature:** _____ **Date:** _____