HealthQuest

4 WEEK TRAINING CLINICS

Boys & Girls Ages 5-8

Beginners

Tuesdays or
Thursdays
5:00-5:30

For the month of MARCH

$50 per player

Reserve Your
Spot TODAY!

COACH
CANDACE BUNNELL

Questions? Call Candace at (908) 782-4009 ext. 234

Register at the Program Desk (908) 782-4009 ext. 233
or Online at healthquest-fitness.com

USA Basketball Clinics 2025

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

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

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

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

Beginners Basketball Clinic – March 2025

Choose your day:

❑ Tuesday 5:00-5:30pm ❑ Thursday 5:00-5:30pm

Boys & Girls Ages 5-8

$50 per player

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 or Medicine or Doctor of Dentistry. This care may be given under whatever conditions necessary to preserve life, limb or well being of my dependent.

Method of Payment
(PLEASE CIRCLE)

Cash **Check** **Credit Card** **HQ Member Charge**

Account Number _____ **Expiration Date:** _____

Signature: _____ **Date:** _____