



**Registration Form**  
**FULL DAY**

**PARTICIPANT NAME:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **POSTAL CODE:** \_\_\_\_\_

**EMERGENCY CONTACT NAME AND NUMBER** \_\_\_\_\_

**METHOD OF PAYMENT:** VISA \_\_\_\_\_ AMEX \_\_\_\_\_ M/C \_\_\_\_\_

**CARD NUMBER:** \_\_\_\_\_ **EXPIRY DATE:** \_\_\_\_\_

**CHEQUE ENCLOSED:** \_\_\_\_\_ (No post dated please)

\*If paying by cheque, space will not be reserved until payment is received.

**DATE OF CLINIC:** July 12-16 \_\_\_\_\_

Aug 09-13 \_\_\_\_\_

Aug 16-20 \_\_\_\_\_

*All Caledon C.C. camp hours are 9 a.m. to 4 p.m      \$275 plus HST =\$310.00*

**AGE** \_\_\_\_\_

**NUMBER OF YEARS PLAYED** \_\_\_\_\_