

Blake Moore
All Round Cricket Coaching
ACT Cricket Association
M: 0416 396 510
ABN: 61 741 344 332



Holiday Program 2012 Registration Form

Athletes Name _____ AGE/D.O.B _____

Address _____

Suburb _____ Postcode _____

Parent/Guardian Name/s _____

Phone (h) _____ (w) _____

(m) _____ email _____

Cricket Club _____ School _____

CRICKETING/SPORTING EXPERIENCE

- Limited Positions
- Entries can be returned via email, fax or post
- **PAYMENT MUST BE MADE PRIOR to the start of clinic - Cheque, Credit Card or Internet Transfer**
- **Cricketer must use all relevant protective equipment to participate. Own Protective equipment to be used.**
- Cost - \$70perday (7-8yrs) | \$200 (9-11yrs) | \$300 (12-15yrs)

Parents, please note that children participate at their own risk

I hereby give permission for _____ to participate in the All Round Cricket Coaching Holiday Program on _____ & agree to the conditions above.

Signed Parent/Guardian _____

Please email your form to bmoore@cricketact.com or fax to **02 6295 7135** or post **Sir Donald Bradman Stand, Level 2 Manuka Oval, PO BOX 3379, Manuka ACT 2603**

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Athletes Full Name:

Next of Kin's Full Name:

Emergency Contact Number:

Photographs &/or Video footage will take place during clinics for the purpose of player development & marketing.

I give permission for my child to be photographed / videoed for player development & marketing purposes.

Yes No

Medical conditions:

Medical conditions, asthma, allergies (food, insect etc): Yes/No

If yes, please detail, include any medical action plans please:

Additional Information:

Indemnity and Release

I acknowledge that there are inherent dangers associated with the Cricket Program which may result in the child being injured. To the extent permitted by law I agree on behalf of the child and in my own right to absolve and indemnify the Program Coordinator, Coaches and State Cricket Association (hereafter known as 'Coaching Staff') from any and all liability for injury, loss or damage however caused arising out of the Childs participation in the Program. I agree both on behalf of my child and in my own right to release and forever discharge the Coaching Staff from all claims that I or the child may have or may have had but for this release arising from the Childs participation in the Program. I authorize the Program Coordinators to arrange medical or hospital treatment (including, without Limitation, ambulance transportation if I am not available to do so and I indemnify the Coaching Staff for all costs associated therewith. I authorise the Coaching Staff or their delegates to obtain immediate ambulance, medical, dental or hospital attention should it be required.

I/we understand that I/we will be informed as soon as possible after the event and in the first instance the person shown as the Emergency Contact Person will be contacted.

I have read understood, acknowledged and agree to the above declaration including the warning, release and indemnity.

Medicare No:

Patient No. On Card:

Expiry Date:

Name of Parent / Guardian:

Signed:

Date: / /