

Sign Up Form
In Season Training
August –October

emergency medical attention for the above applicant from a licensed physician or hospital.

Name _____

Address _____

High School/Grade _____

Home Phone _____

Sport/Position _____

Years of Experience _____

Height _____ Weight _____

Length of Training.

1 – Month

2 – Month

3 – Month

I confirm that my child's health meets medical standards for participation in the physical activities provide by All-Pro Training. I understand that the Training is non-contact but injuries sometimes result from participation. I further understand that neither All-Pro Training or staff will assume responsibility for accidents medical or dental, resulting from training during my child's training on the field's that are provided. I give my consent and approval for the responsibility for All-Pro Training, and staff to act on my behalf in securing

Parent/Guardian Signature:

_____ Date: _____

Phone #: _____

Physician's Name:

_____ Phone #
