East Coast Academic Elite Clinic

www.EastCoastAcademicEliteHoops.com

April 14, 2019  |  9:30am-12:30pm
Lancaster, PA
Franklin & Marshall College | Mayser Center

For girls, Classes of 2020, 2021, & 2022

Learn from and work with coaches from top academic NCAA D3 colleges.
Name _________________________  Graduation Year __________
Position ________  Height ______
Address _______________________________________________
Email __________________________  Cell Phone ____________
Parent Name _________________  Parent Phone _____________
High School _______________________
HS Coach _________________  HS Coach Email______________
Optional Information:
AAU Team: ____________________  AAU Coach: _______________
Class Rank: _______  ACT Score: ________
AAU Coach Email: __________________________  GPA: ______
SAT Math: _________  SAT Reading/Writing: ________

Waiver:
We, the undersigned, for ourselves, our heirs, executors, and administrators, waive and release and forever discharge, EAST COAST ACADEMIC ELITE HOOPS, and HIGH PERFORMANCE HOOPS, LLC, its staff, officers, employees and anyone connected with EAST COAST ACADEMIC ELITE HOOPS and HIGH PERFORMANCE HOOPS, LLC, from any and all rights and claims for damages to personal property which may include accidents, medical, dental, or other expenses incurred as the result of accidents sustained at camp.

Parent/Guardian Name: ______________________________
Parent/Guardian Signature: ___________________________  Date: __________

Mail registration form and payment to:
Kirsten Richter
F&M WBB
P.O. Box 3003
Lancaster, PA 17604
Cost: $85
Make checks payable to:
High Performance Hoops, LLC
Health & Insurance Form

Location: Franklin & Marshall College, Mayser Center, Lancaster, PA
Date: April 14, 2019

Please bring with you to check in on April 14

First Name: __________________________________
Last Name: _________________________________________
Age: ______________  DOB: ________________

Please list any pertinent medical information we should have regarding past injuries, past medical history or suggested physical limitations relating directly to the participant’s ability to participate in camp.

___________________________________________________________
___________________________________________________________

I certify that the above-named individual is able to participate fully in the activity listed above, based on physical examination within 12 months prior to said camp date.

(Signature of Parent) (Date) ____________________________________

Emergency Contact Information
Parent Name __________________________________________
Cell Phone __________________________________________

Insurance Carrier ______________________________________________
Policy Number_________________________________________________
Policy Holder’s Name____________________________________________