The Colts Neck Golf Club
The New Jersey Golf Performance Academy
2024 Junior Golf Registration Form

(Check Program(s))

Spring Clinics (Ages 6 – 13): Monday & Wednesday 4:30pm- 6:00pm: *($450)*

☐ ***Clinic 1****: March 11th – 27th* ☐ ***Clinic 2:*** *April 8th – 24th* ☐ ***Clinic 3:*** *May 6th – 22nd* ☐ ***Clinic 4:*** *June 3rd – 19th*

☐ **Summer Clinic (Ages 6 – 13): July 10th – 26th Wednesday & Friday 5pm – 6:30pm:** *($450)*

☐ **5-Day Summer Camps (Ages 8 – 13): Monday - Friday 9:00am – 3:00pm:** *($850)*

☐ ***Week 1****: 6/24 – 6/28* ☐ ***Week 2****: 7/8 – 7/12* ☐ ***Week 3:*** *7/15 - 7/19* ☐ ***Week 4:*** *7/22 - 7/26*
☐ ***Week 5****: 7/29 – 8/2* ☐ ***Week 6****: 8/5 – 8/9* ☐ ***Week 7:*** *8/12 – 8/16*

Fall Clinics (Ages 6 – 13): Monday & Wednesday 4:30pm- 6:00pm: *($450)*

☐ ***Clinic 1****: Sept. 9th – 25th* ☐ ***Clinic 2****: Oct. 7th – 23rd*

Student(s) Name(s):_____ Member No. (If Applicable):_____
Age(s):_____ Date(s) of Birth:_____
Name of Parent/Guardian:_____ Email:_____
Address:_____ Primary Phone:_____
Secondary Phone:_____ Emergency Contact: _____
Is there anything specific information or instructions we need to know to regarding your child/children?
_____

INDEMNIFICATION*: I agree to allow my child / children to participate in any activity sponsored by the New Jersey Golf Performance Academy at The Colts Neck Golf Club in the above program. I agree to assume all risk and hazards incidental to such participation and release, absolve, and indemnify any claim arising out of injury to my child / children. I also agree to return all equipment issued to my child / children in good condition, except for normal wear and tear, or pay the current replacement costs.*

MEDICAL RELEASE CONSENT AND MEDICAL INSURANCE INFORMATION

I hereby certify that my child/children is/are in good health, has/have had a recent physical and may participate in activities at The Colts Neck Golf Club. In the event of an emergency, I give my permission to my child / children's instructor for my child / children to be given treatment at a local hospital.

Signature of Parent or Guardian: _____

INSURANCE COMPANY:	PHYSICIAN:
ID NUMBER:	PHYSICIAN PHONE:

Spots Are Limited In All Sessions. Payment Due At The Time Of Registration To Secure Spot.

Total Amount Enclosed: $_____ Please charge my account (if applicable)_____

Credit Card#: _____ Exp:_____ CVV:_____ ZIP:_____

Name on Card:_____

Parent/Guardian Signature:_____ DATE:_____

*Please make checks payable to Colts Neck Golf Club. Credit Card payments must be made in person. All deposits and payments are non-refundable.