



**REGISTRATION FORM FOR
SUMMER GOALIE CLINICS
AT WEST MEADOWS ICE ARENA & PLEASANT PRAIRIE**

PLEASE INDICATE WHICH CLINIC(S) YOU WILL BE ATTENDING:

WEST MEADOWS CLINICS - 60 min

- | | |
|---|------|
| <input type="checkbox"/> June 23, 2015 - 7:00 - 8:00p | \$40 |
| <input type="checkbox"/> July 7, 2015 - 6:00 - 7:00p | \$40 |
| <input type="checkbox"/> July 21, 2015 - 6:00 - 7:00p | \$40 |

PLEASANT PRAIRIE CLINICS - 90 min

- | | |
|---|------|
| <input type="checkbox"/> June 11, 2015 - 7:15 - 8:45p | \$55 |
| <input type="checkbox"/> June 25, 2015 - 7:15 - 8:45p | \$55 |
| <input type="checkbox"/> July 9, 2015 - 7:45 - 9:15p | \$55 |
| <input type="checkbox"/> July 23, 2015 - 7:45 - 9:45p | \$55 |

ALL OF THE CLINICS ARE OPEN TO HOUSE, TRAVEL, HIGH SCHOOL AND JUNIOR GOALIES

WE REQUIRE 36 HR NOTICE FOR REGISTERING OR CANCELLATION.

(Times subject to change - we will notify you of any time changes)

You must have fully certified goalie equipment to attend the clinics, PADS staff reserves the right to remove you from the clinics if you do not comply with proper equipment.

Goalie Name (First, last) _____ Age: _____

Address/Town/Zip: _____

Phone (Best contact #): _____ Email: _____

2014-15 Level of Play: _____ Expect to play 2015-16: _____

In case of emergency contact: _____ Phone: _____

Payment type: _____ Check _____ Cash (pay at rink) _____ Credit Card

Please download the form, fill in the information, save and email the form back to us to secure your spot.

Email: roy@padsgoaltending.com

US Mail: P.A.D.S. School of Goaltending, LLC.
PO Box 705
Lake Zurich, IL 60047

Payment information: We accept cash, checks and all major CC.

Clinic Format: All of the clinics will focus on fundamentals, skating, technique

and repetition. Goalies will be grouped by ability, not age.

Medical Treatment Authorization and Liability Release

I, the undersigned acknowledge that I am the parent or guardian of _____, and do hereby grant my permission for my hockey player to attend P.A.D.S. School of Goaltending, LLC. Summer Clinics and to actively and fully participate in all activities thereof. In the event of an injury or illness during these activities, my signature indicates that I agree to allow medical treatment even if I cannot be contacted, and authorize P.A.D.S. School of Goaltending, LLC and /or the local hospital to provide the needed medical treatment they deem necessary.

I hereby release Roy J. Perfetti, and all members of the program’s staff, the host ice facility and its staff, the local hospital and their doctors, agents, employee, and representative and all offices of P.A.D.S. School of Goaltending, LLC. from any and all claims and liabilities arising in any way out of its exercise of this authority. I understand and agree that all bills for any medical/dental care and treatment will be forwarded to me, or my insurance company, and that it will be my responsibility to see that such bill are paid in full.

I have received a copy of the schedule and understand the activities. I understand that full, legal equipment is to be worn properly at all times on the ice or bench.

Parent or guardian’s signature of participant: _____ Date: _____

Goalie’s signature: _____ Date: _____

On behalf of the entire staff and myself we thank you for participating in this event and your loyalty to our program.

Sincerely,

Roy J. Perfetti
President
P.A.D.S. School of Goaltending, LLC