



# Youth Archery Program

administered by Tom Hinojosa/All American Archery of Santa Clara Valley

## **Registration and Authorization Form**

Name of Student \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Student's Mailing Address \_\_\_\_\_

\_\_\_\_\_

### **Parent/Guardian(s)**

Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Email Address** Parent: \_\_\_\_\_

Student: \_\_\_\_\_

Parent's Mailing Address if different from Student's

\_\_\_\_\_

Others authorized to pick up child: \_\_\_\_\_

### **Emergency Contacts**

Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

I authorize representatives of the All American Archery of Santa Clara Valley Youth Program to authorize or administer emergency medical treatment of/to my child.

I understand that in the course of coaching archery or providing emergency medical treatment it may be necessary to touch my child in an instructive and professional manner.

Signature \_\_\_\_\_ Date \_\_\_\_\_