

2009-10

Chugiak/Eagle River Masters and Adult Ski Program Registration and Information Sheet

Name: _____ Age: _____

Address: _____

Phone number: home _____ wk _____ cell _____

E-mail: _____

Ability: _____

Goals for joining: _____

Winter Season: Register Dec. 2 or Jan. 6 in the Beach Lake Chalet

- | | |
|---|------------------|
| <input type="checkbox"/> Schedule 1: December 1- March 5 (ex: 12/24 & 31) | \$225.00 |
| <input type="checkbox"/> Schedule 2: † January 5-March 5 | \$150.00 |
| <input type="checkbox"/> Punch Card: 10 sessions (pick your sessions) | <u>\$120.00</u> |
| | Sub total: _____ |
| <input type="checkbox"/> Parks n Rec. Trail Pin/User Fee (not optional) | \$ 25.00 |
| | Total: _____ |

All sessions run from 6:30-8pm at Beach Lake Ski Trails.
Some weekend sessions will be scheduled at no additional fee.

Please make checks payable to ERNTC [Eagle River Nordic Training Center]

Uniforms are available upon request at any time. Please allow 3 weeks for delivery.

Note: You will also need to be a member of the ERNSC. We will have forms available and we can turn them in for you.

Eagle River Masters & Adult Ski Program Liability Form

I, _____, choose to participate in the Eagle River Masters and Adult Ski Program.

I understand that I will be participating in an active program and will not hold Alaska Nordic Racing, their coaches and officers, and the Eagle River Parks and Recreation Department responsible in case of harm or injury for circumstances unknown.

Name

Date

Medical/Dental Release

I, _____, hereby authorize the coaches and other adult representatives of the Alaska Nordic Racing to obtain such medical or dental care for myself as the coach or adult representative deems necessary. This authorization shall remain in effect during my participation of the Eagle River Masters and all other activities incidental thereto. I agree to be responsible for the cost of such medical or dental care.

The following information is needed by any hospital or practioner not having access to my medical history:

Emergency contact: _____ phone #: _____

Allergies: _____

Medication being taken: _____

Date of last tetanus shot: _____

Other pertinent facts to which the physician should be alerted: _____

Medical insurance company: _____

Group policy number: _____

Dental insurance company: _____

Group policy number: _____

Signature

Date

Home phone: _____ Work number: _____