



2024-2025 SEASON CLINIC FORM

May 14, 15 & 16, 2024
Tryout 5/17/2024 or 5/18/2024

Athlete's Name: _____ Home Phone: (____) _____ - _____

Cell Phone: (____) _____ - _____ School: _____

D.O.B.: ____/____/____ M/F: ____ Age: ____ Grade: ____

Street Address: _____ City: _____ Zip Code: _____

Parent/Guardian: _____ Cell #: (____) _____ - _____

Parent(s) E-mail: _____

In case of an emergency and neither parent can be reached, call:

Name(s): _____ Phone: (____) _____ - _____

Tumbling Skills Level:

PAYMENTS VIA: ZELLE: EVOLUTION.ALLSTARS@YAHOO.COM
VENMO: @BEVERLY-HOOVER

*****OFFICIAL USE ONLY*****

CLINIC FEE: \$45 (Tryout is Free of Charge)

Tryout Fee: \$25 Per Athlete

Reserved Date: _____ PAID: _____ RCVD/BY _____

For office use only

For Official Use Only
Tumbling Level: _____
Position: _____
Team(s): _____

RELEASE FORM MUST BE SINGED

