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TOWN OF GREENFIELD

2022 SUMMER

TENNIS PROGRAM

Summer Tennis will take place at the Middle Grove Town Park on Middle Grove Road. The program will run four consecutive Mondays OR Wednesdays beginning on Monday July 11th and Wednesday July 13th and ending on August 1st and August 3rd. The program focuses on skill development, games and a whole lot of fun. Children will be grouped based on skill level (beginner/intermediate) and age. The program is open to ages 6 and up. Each session will be 45 minutes. PLEASE BE ON TIME!

Please Circle One: Monday **OR** Wednesday

Please Circle one: 8 am session **OR** 9 am session **OR** 4 pm session **OR** 5 pm session

All participants must bring their own racket, water bottle and sunscreen. Mask requirements will be determined based on NYS guidelines.

The registration fee is **\$75 per child**. Please make checks payable to the Town of Greenfield. You can drop off signed forms and fees to the Town Hall or mail to: Rebecca Sewell, Greenfield Town Hall, PO Box 10, Greenfield Center, NY 12833.

Childs Name: _____ DOB: _____ Age: _____

Address: _____

Parent/Guardian Name: _____ Cellphone: _____

Email: _____

As parent or legal guardian, I give full consent for the above named participant in the Greenfield Tennis Program. To my knowledge, he/she has no known disability, illness, or disease which may endanger his/her safety or the safety of others. I further release the Town of Greenfield, its officers, officials, property owners, coaches, referees, any volunteers, other program participants and their families from liability as a result of personal and/or property damage incurred while participating in the tennis program

Parent/Guardian Signature: _____ Date _____

AUTHORIZATION FOR EMERGENCY TREATMENT OF MINORS

Name of Minor: _____ Birthdate: _____

I, Being the parent or legal guardian of the above minor do hereby appoint
The Town of Greenfield
(OR) Authorized Physicians of Hospital
to act on my behalf in authorizing emergency medical, dental, or surgical care and
hospitalization for the above named minor during the period(s) of my absence.

This document will be presented to a physician, dentist, or appropriate hospital representative at such time
as emergency, dental, surgical or hospitalization may be required.

Parent/ Guardian

Name (print): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Signature: _____ Date: _____

Witness

Name (print): _____ Signature: _____

Date: _____

HOSPITALIZATION COVERAGE FOR THE ABOVE NAMED MINOR

Name of Insurance Company: _____

Group Number: _____ Member Number: _____

Family Physician (Name): _____ Phone: _____

Known Allergies: _____

Last Tetanus Toxoid Booster: _____

Other Pertinent Medical Information (i.e. glasses, contact lenses): _____

