Crossover Basketball Camp

The details:

Where: Ageless in Gillespie

When: Sunday Evenings 6-7pm starting January 6thth- January 27th

What: 4 Sixty-minute training sessions

Who: 5^{th}-7^{th} grade boys and girls

Cost: $20

Misc: Limited to 8 athletes. Filled on a first-come-first-serve basis

If you have any questions, please call Ageless at 217-839-2484 or e-mail BeTheChange@ageless-fitness.com. We are here to help!

Please return the form below to Ageless in Gillespie or mail it to: Ageless, 103 North Jersey Street, Gillespie, IL 62033.

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Crossover Basketball Camp

Name: ___________________________

Age: ___________________________

Parents' Names: ___________________________

Phone number: ___________________________

E-mail address: ___________________________

Liability Waiver

As the parent or legal guardian of ____________________________ (print name of child), I hereby give permission for my child to participate in activities at Ageless, LLC. I understand that the program has activities that can involve physical contact with other participants, the ground or equipment, and that there is a resulting risk of physical injury to my child.

I have explained these risks and benefits of participating in this program to my child and my child is in proper physical condition and has no existing injuries or conditions that could jeopardize his/her safety or health, or the safety or health of the other participants.

I therefore release and discharge all liability for any harm or injury suffered directly or indirectly as a result of my child's participation in any activities at Ageless LLC, including but not limited to the Ll' Muscles Exercise Program, whether or not resulting from negligence, and I agree not to sue Ageless, LLC, its representatives, staff, or volunteers on any such claim. I also give permission for the staff, representative, or volunteers of Ageless, LLC to administer first aid or to seek medical care for my child during my child's participation in the program, including transportation of my child to a medical facility for additional treatment that appears necessary.

Print name of Parent/Guardian: ____________________________

Signature of Parent/Guardian: ____________________________

Date: _______________