



Froggie's[®]
www.froggies.net

Camp Sign-up Form

To register, mail form with check payable to: **Froggie's**

1537 Pershing Drive Unit B, San Francisco, Ca 94129 www.froggies.net

Or call: 415 816 9024

2010 Junior Swim & Tennis Camps: McNears Beach Park 201 Cantera Way, San Rafael, CA 94901

June 7-11, 14-18, 21-25 **July** 5-9, 12-16, 19-23, 26-30 **Aug** 9-13, 16-20

Full-Day Camp 9:00am – 4:00pm Half-Day Camp 9:00am – 12:30pm

Registration Form: (2-3 kids per family per camp - 10% discount – be sure to fill out form/s for each child) Age ____

*Adult Camp ____ **Junior Camp ____ *Cardio-Tennis ____ *Tad-Poles ____ *After School Program ____

Parent's Name _____ Phone 1 _____

Student's Name _____ Phone 2 _____

Address _____ E-mail _____

City _____ State _____ Zip _____

1-week **Full-Day Camp \$345.00 – 1-week **Half-Day Camp \$245.00

Private Lesson __\$60 6-pack __\$330 **Semi-Private** __\$70 6-pack __\$390 [\$195 each]

Group of 3 __\$80 6-pack __\$450 [\$150 each] **Group of 4** __\$90 6-pack __\$500 [\$125 each]

Cardio-Tennis: 6-pack__ \$90 **Tad-Pole Tennis:** 6-pack__ \$90 **After School Program** 6-pack__ \$90

Private Group Camps __ to arrange a private group camp or clinic call: (415) 816-9024

Coach Referral _____ Total Amount \$ _____ Payment: ____ Check

Drop-in Rate** -\$20hr *Late fees apply** (\$1 per minute)

Name of Physician _____ Physician's Phone # _____

I do hereby release Froggie's, McNears Beach Park, the Department of Parks and Open Space, the County of Marin and any employees or independent contractors affiliated with these entities from any liability or responsibility for accident or injuries to my above identified children or I may incur. I also authorize McNears Beach Park to consent to X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or specialized supervision of any physician licensed under the provisions of the Medical Practice Act on the staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

Signature (or signature of parent or guardian if registering a minor) _____ Date _____