FLIGHT YOUTH BASKETBALL CLINICS REGISTRATION

PARTICIPANTS NAME: ____

ADDRESS: ____

CITY: ______________________ STATE: ________ ZIP CODE: _______________

EMAIL: ____

AGE: ____

SCHOOL: ____

GENDER: MALE OR FEMALE (CIRCLE ONE)

CLINIC PARTICIPATING IN:

___ SHOOTING CLINIC I ($30.00)

___ SHOOTING CLINIC II ($30.00)

___ SHOOTING CLINIC III ($30.00)

___FUTURE CAMP STARS I ($15.00)

(CHECK ALL THAT APPLY)

PLEASE MAKE PAYMENT TO: **FAYETTEVILLE FLIGHT ABA LLC.**

PARENT SIGNATURE: ____

PAYMENT: $__________ (CHECK, CASH OR MONEY ORDER)

FLIGHT STAFF SIGNATURE: ____

DATE: ____/____/____

ONLINE REGISTRATION AVAILABLE AT [WWW.FAYETTEVILLEFLIGHT.ORG](http://www.fayettevilleflight.org)