



DALEWOOD
GOLF CLUB

WEE-GOLF

Registration form

NAME:(CHILD)_____

AGE:_____

I HAVE MY OWN CLUBS YES___ NO___

PAYMENT CASH___ E-TRANSFER___ DEBIT___ CREDIT___

PARENT/GUARDIAN INFORMATION

NAME:_____

EMAIL:_____

PHONE:_____

CLINIC START DATE

JULY 5TH 5:30PM ___

JULY 5TH 6:30PM ___

JULY 6TH 5:30PM ___

JULY 6TH 6:30PM ___

I AGREE TO ALL IMAGES OF MY CHILD TO BE USED ON SOCIAL MEDIA AND/OR ADVERTISING FOR DALEWOOD GOLF CLUB, WEE-GOLF PROMOTIONS.

YES___

NO___

CLINIC FEE: \$120.00 (PLUS TAXES)