

WEE-GOLF



DALEWOOD
GOLF CLUB

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 4TH 5:30PM ___ JULY 4TH 6:30PM ___

JULY 5TH 5:30PM ___ JULY 5TH 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: \$130.00 (PLUS TAXES)