



Checks payable to:  
Shea Training Systems  
266 Ridge Rd  
Marshfield, Ma 02050

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ CELL/WORK: \_\_\_\_\_  
GRADE (2008-09): \_\_\_\_\_ SCHOOL: \_\_\_\_\_  
INSURANCE COMPANY: \_\_\_\_\_  
T-SHIRT SIZE: \_\_\_\_\_  
EMAIL \_\_\_\_\_

I accept full responsibility for my child's use of all apparatus, appliances, or services whatsoever, owned and operated by this clinic, its Directors, Representatives, and Agents harmless from any and all loss, claim, injury, damage, or liability sustained or incurred by me resulting there from.

I vouch that my child is cleared by his/her primary physician and any medical professionals consulted at any time previous to this clinic to partake in competitive or strenuous physical activity. If there are pre-existing conditions, I understand that my child is to have written and documented medical clearance from his/her physician as not to place them in harm's way.

PARENT SIGNATURE \_\_\_\_\_  
PRINT \_\_\_\_\_  
DATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_