Children's Fishing Clinic

P O Box 410583, Melbourne, FL 32941

Registration Form

Youngsters are invited to take part in the **ACADEMIC ANGLERS CHILDREN'S FISHING CLINIC**. Fill out this application and mail to the below address. Names will be recorded in the order they are received, and youngsters will be notified as openings become available. **The applicant's parent or guardian must sign all applications.**

Child's Name _____Age _____

Parents Name_____ Email:_____

Address_____

City _____State _____Zip _____

Work Phone _____

Cell Phone_____

Parent / Guardian consent, release of liability, and authorization consenting to treatment of minor injury.

I, the undersigned parent and / or legal guardian of

_____, Do hereby grant permission for him/her to participate in activities of the Academic Anglers Children's Fishing Clinic and to ride in or be a passenger on any vessel or vehicle of whatever nature and to use equipment and facilities made available by the Academic Anglers Children's Fishing Clinic and, in consideration of the opportunity afforded to such minor, release the Academic Anglers, LLC and its Children's Fishing Clinic and other persons participating in any of its programs or activities from all causes of action, actions, damage, claims and demands, in law or in equity, of every kind and character, I may now or hereafter have against them.

In the event of injury, I, the undersigned parent or legal guardian, do hereby authorized the Academic Anglers Children's Fishing Clinic as agent for the undersigned to consent to any X-Ray examination, and anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any licensed physician or surgeon. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of the aforesaid agent to give specific consent to any and all diagnosis, treatment or hospital care which the aforesaid mentioned physician in the exercised of his best judgment many deem advisable.

_____

Parent / Guardian Signature Date

Return to: **Academic Anglers**
P.O. Box 410583
Melbourne, FL 32940
or
Fax: (321) 255-1195