



# SUMMER



# JUNIOR TENNIS CLINICS

**Eldon Roark/Whitehaven Tennis Center**

1500 Finley Rd.

Memphis, TN 38116

**338-1308 or 237-5677**

**[slang@tennismemphis.org](mailto:slang@tennismemphis.org)**

**USTA Tournament  
Player Development Training**

**June 8<sup>th</sup> thru July 23<sup>rd</sup>**

(6 weeks)

**Mondays, Tuesdays, Wednesdays, Thursdays  
1.30pm-3.30pm**

Cost per child & payment options

**\$64 per week, \$20 per day or \$300 summer pass**

**CLINICS TAUGHT BY STEPHEN LANG, USPTA CERTIFIED TENNIS**

**PROFESSIONAL & TENNIS MEMPHIS EXECUTIVE DIRECTOR**



*City of Memphis,  
Division of Park Services*

**--- COMPLETE REGISTRATION FORM ON BACK ----**

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## **2009 SUMMER JR. TENNIS CLINICS REGISTRATION FORM**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_-\_\_\_\_-\_\_\_\_ Male / Female

Street Address Apt. # City State Zip

Parent's E-mail \_\_\_\_\_ Parent's Name \_\_\_\_\_

Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Cost per child & payment options  
**\$65 per week, \$24 per day or \$300 summer pass**

### ONLY CHECK THE WEEKS THAT YOU ARE APPYING THE PAYMENT

Week 1 June 8 -11       Week 1 June 15 -18       Week 1 June 22 -25  
 Week 1 July 6-9       Week 1 July 13-16       Week 1 July 20 -23

Payment Amount: \$ \_\_\_\_\_

**Waiver:** I, the undersigned parent or guardian, hereby consent for my child to participate in the Summer Junior Clinics. In consideration of participation in the program, I hereby indemnify and hold harmless the City of Memphis, Tennis Memphis and any sponsors of the program and their respective employees, staff, officers, agents, successors and assigns and I release the same from any and all liability for any injury or illness which may be suffered by my child arising out of or in any way connected with the summer program. I assume the risk for such injury or illness. I, the undersigned, have read this Release and understand all of its terms and hereby execute it voluntarily with all knowledge and understanding of its significance. **PARENT'S AUTHORIZATION:** In the event I (we) cannot be reached in an emergency, the undersigned gives permission to the physician selected by TMI to hospitalize, administer treatment or secure proper treatment for my child.

List any medical condition or special needs: \_\_\_\_\_

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Office Use Only: Date \_\_\_\_\_ Amount Paid \$ \_\_\_\_\_ Cash  Ck # \_\_\_\_\_ Credit Card  Staff \_\_\_\_\_

