

Teneo High Jump Festival

JUMPER & CAMPER REGISTRATION FORM

Please circle one:

- \$30 High Jump Festival Competition ONLY - June 19th** (\$45 if mailed after June 9th or at the door)
- \$120 next day Festival Camp/Clinic with the elite athletes ONLY – June 20th** (\$135 if mailed after June 9th or at the door, if there is space available- call first)
- \$135 for BOTH Festival Competition AND next day Festival Camp/Clinic – June 19 & 20** (\$180 if mailed after June 9th or at the door, if there is space available- call first)
- \$40 for Coaches at Festival Camp/Clinic** (\$55 if mailed after June 9th or at the door, if there is space available- call first).

Athlete Name: _____

School/Club: _____

PB: _____

Mother and Father's name _____

Address:

Street: _____

City: _____ State: _____ ZIP: _____

Home Tel. # _____

Parent Work Tel: # _____

E-mail: _____

WAIVER AND DISCLAIMER: I know of no mental or physical problems which may affect me or my child's ability to safely participate in the Teneo Jumps Festival. Coaches and staff is authorized to attend to any health problem or injury to me or my child while attending the Teneo Jumps Festival. Neither I nor my child will hold Teneo Jumps Festival liable for any injuries or expenses while me or my child are at the Festival. I hereby authorize my child's participation in the Teneo Jumps Festival. I agree that photos or video taken at the Festival of me or my child may be used in media or promotional materials for the Teneo Jumps Festival. I understand that this is a USATF sanctioned competition and the video and pictures of the competition will be posted at the website (www.teneojumpsfestival.org , www.kangarootrackclub.org , www.teneoathletics.com & The Kangaroo Track Club YouTube Channel) in order to promote this competition and the sport.

Participant Signature _____ Parent signature (if participant is under 18 years old) _____

_____ Date

CONSENT FOR MEDICAL TREATMENT: As the parent or legal guardian of a participant in the Teneo Jumps Festival, I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my dependent. Parent/Legal Guardian:

Signature: _____ Date: _____

Please make all checks payable to **Kangaroo Athletics LLC** and mail it to: **PO BOX 94, Farmington, MN 55024**