DEVELOPING TALENT SQUAD MEMBERSHIP APPLICATION 2018-2019

|  |  |  |  |
| --- | --- | --- | --- |
| SURNAME: |  | FORENAME(S): |  |
| ADDRESS: |  |
|  |  | POST CODE: |  |
| DATE OF BIRTH: |  | SCHOOL: |  |
| EMAIL: |  |

|  |
| --- |
| I would like to accept a place in the Developing Talent Squad of the West Cheshire Performance Centre for 2018-2019. I understand that I am required to enter 4 BE Ranking Tournaments, plus the Junior County Championships and Performance Centre Tournament. I will endeavour to attend as many of the training sessions as possible. |
| Signed: (player)  |  | Date: |  |
|  |
| **Payment Option** – *please tick as appropriate – dates for post dated cheques (payable to WCPC) can be found on the invitation letter* |
| **Option 1** – 1 cheque for £976.00 |  | **Option 2** – 1 cheque for £326.00, 2 cheques for £325.00 |  |
|  |  |  |
| **Option 3 –** 1 payment of £85.00, 11 payments of £81.00(STO) |  |  |  |
|  |
| We would like to take photographs at the various County organised events throughout the season to allow us to promote Junior Badminton in Cheshire. We would therefore be grateful if you would complete the following: |
|  | **YES** |  | **NO** |
| I give permission for my child’s photograph to be used by West Cheshire Performance Centre |  |  |  |
|  |  |  |  |
| I give permission for my child’s image to be used on the Cheshire Badminton Website |  |  |  |
|  |  |  |  |
| I agree to be contacted by email |  |  |  |
| I understand the requirement for my child to enter 6 Tournaments and attend as many training sessions as possible and will support them in these things. |
| Signed: (parent/guardian) |  | Date: |  |

**EMERGENCY CONTACT INFORMATION:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Relationship | Home  | Mobile |
| 1. |  |  |  |  |
| 2. |  |  |  |  |

**MEDICAL INFORMATION:**

|  |  |  |  |
| --- | --- | --- | --- |
| GP Name:  |  | Surgery Tel. No: |  |
| Address: |  |
|  |
| Please list any illnesses you may have or any medication that you need to take? (Include blood conditions, epilepsy, asthma and any know allergies). Please continue overleaf if necessary. |
|  |
| Please let us know if you have any mobility, hearing or sight difficulties: |
|  |
| Consent:  | I / We agree that the information given above is correct to our knowledge and that a responsible adult may take the decision to seek or apply First Aid treatment if required in my / our absence. |
| Signed by Next of Kin: |  | Date: |  |
| Name in block capitals: |  |
| Please complete this form and return, with cheques, if appropriate, to Mrs K Vickers, Melgarth, Village Road, Christleton, CH3 7AS by the due date. |