



# After School Basketball



- Place:** CLEARSPRING ES
- Day/Dates:** FRIDAYS FEBRUARY 21 MARCH 7, 14, 21, 28
- Time:** 3:30pm – 4:30pm
- Who:** Students in Grades / 1<sup>st</sup> – 5<sup>th</sup>
- Cost:** \$75
- Registration:** Zelle Payment To: | 2404265004 | Email This form to: [1uphandles@gmail.com](mailto:1uphandles@gmail.com) |
- Registration:** Venmo Payment To: | @Kevin-Thompson-51 | Email This form to: [1uphandles@gmail.com](mailto:1uphandles@gmail.com) |
- Location:** School Gym
- Contact #/ Email:** Kevin (240) 426-5004 or [1uphandles@gmail.com](mailto:1uphandles@gmail.com) (Questions)
- Special Note:** Minimum of 10 participants
- Dismissal:** Aftercare, Car Rider, Walker (Please Circle One)

### Registration Information

Participant Name: \_\_\_\_\_  
 Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_ School: **CES**  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_  
 Cell Phone #: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Special Needs/Health Concerns: \_\_\_\_\_

### **Parental Policy Agreement**

I hereby certify that my child is in normal health, covered by medical insurance, and capable of safe participation in After School Basketball by 1 Up Handles Inc. Any Special needs or health conditions have been stated. The organizers and staff are not responsible for any damage or injury incidental to the conduct of this program. I hereby authorize the 1 Up Handles Inc. staff to obtain medical treatment for my child in the event that parent/guardian or emergency contact cannot be reached.

Signature of Parent/Guardian: \_\_\_\_\_

(These materials are neither sponsored nor endorsed by the Board of Education of Montgomery County, the superintendent, or this school)