

For Office Use Only
 ___ Program Application
 ___ Insurance Medical Release
 ___ Mbsef Release
 ___ Scholarship Request
 ___ Loaner Bike Request
 ___ Date Entered

MT. BACHELOR SPORTS EDUCATION FOUNDATION



2017 MBSEF CYCLING JUNIOR PROGRAM ENROLLMENT

Participant Name _____ Parent E-Mail _____
 (Please Print Legibly)

Athlete E-Mail _____
 (Email Addresses For Newsletters, Updates and Training Changes)

Birth Date ____/____/____ Age ____ Sex ____

Mailing Address _____ City _____ State _____ Zip Code _____

Father's Name _____ Home Phone # (____) _____ Cell # (____) _____

Mother's Name _____ Home Phone # (____) _____ Cell # (____) _____

Were you an MBSEF member last winter season? ___ Yes ___ No
 If YES, which program? _____ Coach: _____
 If NO, attach MBSEF Liability Waiver and Release, and Medical Form.

(Enroll by checking the appropriate program in boxes below; sign at bottom; complete separate liability form)

SESSION I	Age 7-14
MBSEF CLUB MTB CYCLING	
WEDNESDAYS April 5, 12, 19, 26	
FRIDAYS (SEVEN PEAKS ONLY) April 7,14,21,28	
Yes, I want picked up from my school! School _____	
Wednesdays After School	<input type="checkbox"/> \$115
Fridays After School (Seven Peaks Only)	<input type="checkbox"/> \$115
No, I do not want to be picked up from school. I will meet at MBSEF (Wed Session Only)	
	<input type="checkbox"/> \$ 85
Please confirm pick up at an outlying school prior to the program starting. You may need to drop off your rider at our office.	

SESSION II	Age 7-14
MBSEF CLUB MTB CYCLING	
WEDNESDAYS May 3,10,24,31, Skips May 17	
FRIDAYS (SEVEN PEAKS ONLY) May5,12,26, June 2 Skips May 19	
Yes, I want picked up from my school! School _____	
Wednesdays After School	<input type="checkbox"/> \$115
Fridays After School (Seven Peaks Only)	<input type="checkbox"/> \$115
No, I do not want to be picked up from school. I will meet at MBSEF (Wed Session Only)	
	<input type="checkbox"/> \$ 85
Please confirm pick up at an outlying school prior to the program starting. You may need to drop off your rider at our office.	

Payment: Cash Check Visa Mastercard

Amount Paid \$ _____ Date Paid _____ Check/Ref # _____ Balance Due _____

Credit Card # _____ Exp _____

Name _____ CVC Code _____

Signature _____

Office Use Only: Acct. Initials _____ Date Posted _____

SUBTOTAL	\$ _____
OPTIONAL DONATION TAX DEDUCTIBLE	\$ _____
TOTAL	\$ _____

PARENT SIGNATURE _____ DATE _____