

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

MT. BACHELOR SPORTS EDUCATION FOUNDATION



2018 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 4, 11, 18, 25		
FRIDAYS (SEVEN PEAKS/ST. FRANCIS ONLY) April 6,13,20,27		
Yes, I want picked up from my school! School _____		
Wednesdays After School	<input type="checkbox"/>	\$125
Fridays After School	<input type="checkbox"/>	\$125
No, I do not want to be picked up from school. I will meet at trailhead (Wed Session Only)		
	<input type="checkbox"/>	\$100
Please confirm pick up at an outlying school prior to the program starting. You may need to drop off your rider at the trailhead.		

SESSION II		Age 7-14
MBSEF CLUB MTB CYCLING		
WEDNESDAYS May 2,9,23,30 Skips May 16		
FRIDAYS (SEVEN PEAKS ONLY) May4,11,25, June 1 Skips May 18		
Yes, I want picked up from my school! School _____		
Wednesdays After School	<input type="checkbox"/>	\$125
Fridays After School	<input type="checkbox"/>	\$125
No, I do not want to be picked up from school. I will meet at trailhead (Wed Session Only)		
	<input type="checkbox"/>	\$100
Please confirm pick up at an outlying school prior to the program starting. You may need to drop off your rider at the trailhead.		

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 _____