



Modified Academy of Fencing

2009 Tournament

PARTICIPANT ENTRY FORM 2009

Name: _____
 Address: _____

 City: _____
 State: _____
 Zip: _____

D.O.B. _____
 (Required if under 18)
 Instructor: _____
 Day Tel: _____
 Eve Tel: _____
 E-mail: _____

Check each event you are participating in below:

Chk	Event	Date	Check-In By	MAF Mem	Non-MAF	Sub-Total
	Mixed Y11 Foil	May 9, 2009	9:00 AM	\$18	\$20	
	Women's Sabre Open	May 9, 2009	11:00 AM	\$18	\$20	
	Men's Sabre Open	May 9, 2009	11:00 AM	\$18	\$20	
	Mixed Y14 Foil	May 30, 2009	9:00 AM	\$18	\$20	
	Women's Foil Open	May 30, 2009	11:00 AM	\$18	\$20	
	Men's Foil Open	May 30, 2009	11:00 AM	\$18	\$20	
	Mixed Y16 Foil	June 6, 2009	9:00 AM	\$18	\$20	
	Women's Epee Open	June 6, 2009	11:00 AM	\$18	\$20	
	Men's Epee Open	June 6, 2009	11:00 AM	\$18	\$20	
Total:						

Payment at door: Please make your check payable to: Modified Academy of Fencing or by cash (Must be exact amount)

Age: Y11: DOB Must be after 8/1/1997

Y16: DOB Must be after 8/1/1992

Y14: DOB Must be after 8/1/1994

ALL PARTICIPANTS MUST READ AND SIGN EACH OF THE FOLLOWING STATEMENTS

(For athletes under the age of 18, a parent or guardian must also sign)

Waiver of Liability: Upon entering this tournament under the auspices of the MAF, I agree to abide by the current rules of the MAF. I enter this tournament at my own risk and release the MAF and its sponsors, referees, and tournament organizers from any liability. The undersigned certifies that the birth date of the individual is as stated on the entry form.

Fencer's signature / Date

Signature of Parent or Guardian for minor / Date

CONSENT FOR MEDICAL TREATMENT:

This is to certify that on this date I, _____, give my consent to the MAF and its representatives to obtain medical care from any licensed physician, hospital or clinic for the above named athlete for any injury or illness that may arise during activities associated with MAF Annual Tournament Events.

Fencer's signature / Date

Signature of Parent or Guardian for minor / Date

If said athlete is covered by any insurance company, please complete the following (type or print legibly):

Name of Insurance Carrier: _____
 Name of Policyholder: _____
 Policy number: _____
 Phone Number of Carrier: _____

