

**ONE DAY CO-ED  
STUNT CLINICS  
REGISTRATION FORM**

Date of clinic \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Email Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Parents Name \_\_\_\_\_

School Attending \_\_\_\_\_

Grade or Classification \_\_\_\_\_

**Emergency Contact Information**

Name \_\_\_\_\_

Phone Number \_\_\_\_\_

**Registration fee \$35.00**

**Send to**

**Attn Ben Rotton**

**UNA Athletics**

**UNA box 5071**

**Florence Al, 35632**