

ESAD European Soccer Clinics

Winter Clinics 9 weeks

Starts **November 30th 2009 -**

Concludes **February 2010**

Two locations:

Worcester MA and Thompson CT.

Boys & Girls Ages 6 – 17



For information Contact: Coach Darman 508-410-6944 / Coach Simone 508-410-1506

Winter Clinic Schedule

Session# / Day	Session Begins	Location	Time	Type of Clinic	Age Group	Cost
#1 /Sunday	Dec. 13 th 2009	Thompson CT Marianapolis Prep	8:30am -10:30	Intermediate Footworks	U7 – U10	\$150.00
#2 /Sunday	Dec. 13 th 2009	Thompson CT Marianapolis Prep	10:30am-12:30	Intermediate Footworks/Striker	All ages	\$150.00
#3 /Sunday	Dec. 13 th 2009	Thompson CT Marianapolis Prep	12:30am - 2:30	Advanced Footworks /Striker	All ages	\$150.00
#4 /Monday	Nov. 30 th 2009	Worcester Elm Park School	5:00pm - 6:30	Junior Academy	U7 – U10	\$110.00
#5 /Monday	Nov. 30 th 2009	Worcester Elm Park School	6:30pm - 8:30	Intermediate Footworks /Striker	All ages	\$150.00
#6/Wednesday	Dec. 2 nd 2009	Worcester Elm Park School	6:00pm - 8:00	Advanced Footworks /Striker	U12-U18	\$150.00

Directions; Information; Registration; On-Line at www.FCNapoli.com/Clinic

Mail Check and mail registration below to: Esad Clinics, PO Box 494 Worc. MA 01613

Athlete Name: _____ Age: _____ Phone: _____

Address: _____ (circle) Reg for Session # 1 – 2 – 3 – 4 – 5 - 6

The above named soccer player has my permission to participate in the **ESAD European Soccer Academy and / or Clinics**. I further certify that him/her is capable of participating in a strenuous physical activity, to wit soccer. I also agree to hold harmless the F.C. Napoli soccer club, its staff, agents, the facility or anyone affiliated with **ESAD European Soccer** from any and all injuries which may be sustained by the player during his/her participating in the try out. In case of emergency, I understand every attempt will be made to care for the above named player. I give my permission to the tending physician to render medical treatment to the participant, including (if necessary) hospitalization. Any expense arising from or illness is the responsibility of the person signing below. Clinic registration is complete when payment is received.

Parent Signature: _____ Date: ____/____/____