

WALTER E. WRIGHT
MEMORIAL BASKETBALL TOURNAMENT
SAINT MARK PARISH CENTER

DIVISION: Circle: BOYS GIRLS AGE Circle: J.J.V. JV VARSITY

TEAM NAME: _____

COACH: _____ ASSIST COACH: _____

WORK: (____) ____ - _____ WORK: (____) ____ - _____

HOME: (____) ____ - _____ HOME: (____) ____ - _____

CELL: (____) ____ - _____ CELL: (____) ____ - _____

E-MAIL: _____ EMAIL: _____

NAME	UNIFORM #	GRADE	DATE OF BIRTH
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			

I certify that the above information is true and that I have informed each parent or legal guardian of the possibility that their child may be physically injured as a result of participating in this sports activity. Each parent or legal guardian of the above minor child has granted permission for their child to participate in this basketball tournament and each minor child is covered by medical insurance.

X _____
Signature of Coach

DATE: ___/___/___

Please make checks payable to:

St Mark Basketball Tournament

Please return to:

Tom Kulhawik
797 Wilcoxson Avenue
Stratford, CT 06614
(203) 337-6132
tom@hitekracing.com