

**MARK HAWALD'S FALL WRESTLING CLINIC**

Sunday, November 6th, 2011

Dover High School

520 North Walnut Street

Dover, Ohio 44622

**SCHEDULE** 9:00am – 10:00am Check-in  
10:00am – 1:00pm Clinic

**FORMAT** The clinic will introduce new technique, focus on drilling properly, and give participants an opportunity to wrestle live.

**COST** \$10 per wrestler before November 6th. \$15 on November 6<sup>th</sup> (if space is available).

**REGISTRATION** Three Ways to Register  
1. Register and pay online at <http://www.hawaldwrestling.com/page/Clinics> and bring form below on November 6<sup>th</sup>  
2. Mail form below with payment to:  
Wrestling Office; 1972 Clark Avenue; Alliance, Ohio 44601  
3. Bring form and payment on November 6<sup>th</sup> (cost is \$15)

**QUESTIONS** Visit [www.hawaldwrestling.com](http://www.hawaldwrestling.com) or email [hawaldwrestling@gmail.com](mailto:hawaldwrestling@gmail.com)

**Registration**

Name \_\_\_\_\_ Grade \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_ School \_\_\_\_\_  
Parent's Name \_\_\_\_\_ E-mail \_\_\_\_\_  
Phone # (home) \_\_\_\_\_ Phone # (cell) \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Emergency Contact Phone #: \_\_\_\_\_

**Parental Consent**

I hereby request that you accept this application for enrollment in Mark Hawald's Wrestling Clinic at Dover High School. In consideration of your acceptance of this application, I hereby release the Mark Hawald, Dover High School, and all other associated parties from all claims on account of injuries which may be sustained by my child while attending the clinic.

**Parent or guardian (please print)** \_\_\_\_\_

**Signature of parent or guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

Mail this form to: Wrestling Office  
1972 Clark Ave  
Alliance, Ohio 44601

Checks Payable to: MH Wrestling