

Membership form **Courtown BMX Club**

Name _____

Address _____

Date of birth _____

Home phone _____

mobile _____

Email _____

Parent/guardian name _____

Relationship to child _____

Address _____

Home phone _____

mobile _____

Email _____

Any medical history / allergies please

state _____

Doctor's name _____

Doctor's address _____

Doctors phone number _____

(ICE) in case of emergency

Name _____ contact number _____

Permission for photos to be taken yes no

Permission for videos to be taken yes no

(For use on social media)

Are you a member of another club yes no

Name of club _____

Cycling Ireland number _____

Race number _____

I agree to abide by Courtown BMX club code of ethics, club rules and constitution

Signed _____

Date: _____

Date membership taken out _____

Fee paid _____

Signed _____