Contact Information:

Name:____

Address: ____

City: ____

Zip Code: ____

Phone Number: ____

Email: ____

Event Information:

Name of Camp/Clinic/Tournament/Event:

____

Sport: ____

Location of the Event: ____

Address: ____

City: ____

Zip Code: ____

Event Start Date: ____

Event End Date: ____

*If the dates are no concurrent, please list all dates
Additional Insured Information (If Applicable)

Name:____

Address: ____

City: ____

Zip Code: ____

Manager/Lessors on Premises: _________________________________

Name:____

Address: ____

City: ____

Zip Code: ____

Manager/Lessors on Premises: _________________________________

Name:____

Address: ____

City: ____

Zip Code: ____

Manager/Lessors on Premises: _________________________________

On the day your event starts, please submit rosters (first and last names) to the NHSCA. You will be charged accordingly and receive your receipt via email.

Payment Info:

Name on Card: _________________________

Number: ______________________________

Expiration: ____________________________

CVV: _________________________________