REGISTRATION FORM:

*We must have a minimum of 20 signed up to perform clinic

Name: ____

Parent's Name: ______________________ Emergency Contact: __________________

Address: ____

City: ____________________________ State: ___________ Zip: _____________

E-mail: ____

Age: _______ School: ____

Cell: ____________________________

T-shirt size: S M L XL

Dates you are attending: January 10 17 24

Lunch: Turkey or Ham Sandwich / comes with chips, water, and cookie

Waiver:

MEDICAL RELEASE AGREEMENT

THIS IS TO CERTIFY THAT I HAVE NO KNOWN MEDICAL OR PHYSICAL PROBLEM THAT WOULD PROHIBIT MY PARTICIPATION IN ATHLETICS. FURTHERMORE, I AGREE TO HOLD HARMLESS VOLLEYCHICK.COM AND ITS COACHING STAFF SHOULD I ENCOUNTER ANY INJURY OR MEDICAL PROBLEM WHILE PARTICIPATING IN THE VOLLEYCHICK BEACH CLINICS.

I UNDERSTAND THAT VOLLEYCHICK.COM DOES NOT CARY INSURANCE FOR ACCIDENT OR INJURY TO ME.

I ACCEPT ALL RISKS OF INJURY DURING PARTICIPATION IN PHYSICAL ACTIVITIES AND AUTHORIZE THE COACHING STAFF TO PROVIDE TREATMENT TO THE BEST OF THEIR KNOWLEDGE, AND CALL FOR EMERGENCY ASSISTANCE IF NEEDED FOR WHICH SERVICES I SHALL PAY.

STUDENT/ATHLETE SIGNATURE:_______________________________________DATE:_________________

IF UNDER 18: PARENT/GUARDIAN SIGNATURE:_____________________________DATE:_________________