

14th Annual OA Volleyball Youth Clinic



REGISTRATION AND WAIVER

PLAYER'S NAME: _____

ADDRESS: _____

PHONE NUMBER: (H) _____ (C) _____

PARENT EMAIL: _____

EMERGENCY CONTACT: _____

EMERG. CONT. PHONE: _____

PLAYER AGE _____ GRADE LEVEL AS OF Sept. 2021: _____

SIZE T-SHIRT: (ADULT) S M L XL

I give permission for my child, _____ to participate in the Oliver Ames High School Volleyball Clinic. I acknowledge that this clinic is voluntary, and that my child, with my consent, is choosing to participate. I verify that my child has medical insurance, and that my child is medically and physically fit to participate in this clinic. Furthermore, I, the undersigned parent or guardian of the minor listed above, forever RELEASE, acquit, discharge, and agree to hold harmless the Town of Easton and Easton Public Schools, its officers and agents, from any and all actions, causes of action, and claims on account of, or in any way growing out of, either directly or indirectly, all known and unknown personal injuries or property damage which I may now or hereafter have as the parent of said minor, and also any damages which said minor has or may hereafter acquire either before or after my child has reached the age of majority as a result of participating in the activity.

I give permission for my child named above to receive medical attention, including but not limited to, treatment by a licensed trainer, and to be transported in emergency vehicles should any incident occur requiring such attention.

Signature of Parent/Guardian

Date

Medical Insurance Carrier

Policy Number