

St. Michael Parish School
VOLLEYBALL REGISTRATION FORM

Registration Fee: \$20.00

Name: _____ Date: _____

Address: _____

City/State/Zip: _____ Phone: _____

Birthdate: _____ Grade Next Year: _____

School: _____

Allergies: _____

Current Medications: _____

Health Problems: _____

Date of Last Tetanus Shot: _____

Name of Physician: _____ Phone: _____

PARENTAL HELP

Please indicate what you would be able to help with. Each family must volunteer for one area.

Mother's Name: _____

Father's Name: _____

___ Clock Operator

___ Admissions

___ Gym Clean-up

___ Concession Stand

___ Scorekeeper

___ First Aid Supplies

MEDICAL RELEASE

I, parent or guardian of _____, hereby give approval for participation in St. Michael's activities including practice sessions, games, and post-season tournament play. This authorization and medical release covers all participation in or out of the state of West Virginia and covers a time period from _____ to _____.

I hereby grant permission to managing personnel of the team or other responsible representatives to authorize and obtain medical care from any licensed physicians, hospital or medical facility should the player become ill or injured while participating in St. Michael's activities and when neither parent or legal guardian is available to grant authorization for emergency treatment. I assume all risks and hazards incidental to such participation, including transportation to and from the activities, not covered by insurance. I hereby waive, release, absolve, indemnify and agree to hold harmless the managing personnel of the team, organizers, sponsors, supervisors, participant, and persons transporting the player to and from activities, for any claim arising out of an injury to the player that is not covered by insurance.

I further agree to furnish proof of age to managing personnel when required. I hereby agree to assume all expenses for medical care related to any injury sustained to the player when taken to a licensed physician, hospital or medical clinic.

Signature of Parent or Legal Guardian

Relationship

MEDICAL INSURANCE INFORMATION

Name of Insurance Company

Policy ID Number

In the event of any emergency, contact: _____ Phone: _____