Girl's Lacrosse Player's Clinic Feb. 20, 2010 Ballard High School, Seattle

REGISTRATION FORM

Grades 5 to 8: 9:30 a.m. to 11:30 a.m. Grades 9 to 12: 12:30 p.m. to 2:30 p.m.

*****Registration Form must be completed before players may participate in the Clinic*****

Please send Registration Form with payment (checks payable to WSLA) to:
Jessanne Allen
2044 217th Pl NE
Sammamish, WA 98074

Fees: $15.00 (pre-register 3 days before the clinic)

$17.00 (day of clinic)

Please Print:
Name _____ Grade _____ School _____
Home Phone _____ Number of years you have played _____
EMERGENCY/CELL PHONE _____

PARTICIPATION RELEASE

(Name of Participant) _____ has my permission to participate in the Girl's Lacrosse Player's Clinic.

The undersigned hereby agree to release and hold the Washington School Girls Lacrosse Association ("WSLA") and any of its coaches, administrators, or volunteers harmless from any and all claims arising out of any of the activities connected with the Player's Clinic. The undersigned participant and parent/guardian acknowledge, agree, and represent that they understand the nature of the activities involved in participation in the clinic and fully understand that participation in the sport of lacrosse involves risks and danger of bodily injury.

The undersigned have read this agreement, fully understand its terms, understand that they have given up substantial rights by signing it and have signed it freely and without any inducement or assurances. The undersigned intends it to be a complete and unconditional release of all liability to the greatest extent allowed by law.

_____ _____
PRINT Participant Name Date PRINT Parent or Guardian Name Date

_____ _____
Participant Signature *Date* *Parent or Guardian Signature* Date

MEDICAL/INSURANCE INFORMATION

I, the undersigned, hereby certify that I am the parent/legal guardian of the participant. I hereby give permission for the staff of the Player's Clinic to seek appropriate medical attention for the participant for medical attention to be given and for the participant to receive medical attention in the event of accident, injury, or illness. I will be responsible for any and all costs of medical attention and treatment. I, the undersigned, for myself, my heirs, executors, and administrators, waive, release and forever discharge the WSLA and its staff, officers, agents, employees, representatives, successors, and assigns from any and all liability, claims, demands, actions, and causes of actions whatsoever arising out of or related to any loss, personal injury, or property damage that may be sustained or occur during participation in the Player's Clinic.

Insurance Company_____ Policy Number _____

_____ _____
Participant Signature *Date* *Parent or Guardian Signature* Date

Please list any relevant medical conditions or allergies. List "None" if there are none.

_____