

CAVALRY VOLLEYBALL
Fall 2018 Registration Form and Releases

Participant's Name: _____

Address: _____ **City:** _____ **Zip:** _____

School: _____ **'17-'18 Grade:** _____ **DOB:** _____

T-shirt size: _____

Parent/Guardian Names & Phone #s: _____

Email Address(es): _____

LIABILITY RELEASE AND WAIVER:

I hereby give permission for the minor participant identified above to participate in the Cavalry Volleyball program. I understand that volleyball practice and competitions are physical activities that present a risk of physical injury to the minor participant. I further understand that Cavalry Volleyball Inc., its directors, coaches, sponsors and volunteers have no responsibility and assume no responsibility for injuries which my child may suffer while participating in this program.

I hereby, for myself, my spouse, if any, our heirs and personal representatives, waive and release any and all claims for damages we may have against Cavalry Volleyball Inc., its directors, coaches, sponsors, volunteers, the driver of any motor vehicle transporting the minor participants, and the agents, representatives and/or assigns of any such person, for any injury my child may suffer due to participation in this program. I further understand that Cavalry Volleyball Inc. does not carry accident insurance for the benefit of my child and agree that I will assume full responsibility for my child's medical expenses and well-being.

Signature of Parent or Guardian: _____ **Date:** _____

MEDICAL INFORMATION AND RELEASE:

As the parent or legal guardian of the minor-child participant identified above, I do hereby give authority to the directors and coaches of the Cavalry Volleyball program to obtain all necessary medical assistance for my child (identified as "Participant" above) in the event of an emergency, including the assistance of a physician and/or hospital. This authorization is granted in situations where the need for medical care is believed by Cavalry Volleyball directors and/or coaches to be immediate and where a parent cannot be reached immediately at the numbers provided on the registration form.

Signature of Parent or Guardian: _____ **Date:** _____

Please check any of the following medical conditions which may be applicable (describe if necessary)
_____ glasses _____ epilepsy _____ allergies (specify: _____)
_____ asthma _____ hearing loss _____ daily medications (specify: _____)
_____ diabetes _____ other (specify: _____)