

## REGISTRATION & ACKNOWLEDGMENT OF RISK FORM ARCHBOLD VOLLEYBALL CLINICS 2024

## PARTICIPANT'S NAME:

ADDRESS: PHONE:

OTHER PHONE:

DATE OF BIRTH: UPCOMING GRADE:

EMERGENCY CONTACT #1: EMERGENCY CONTACT #2:

PHONE:

DOCTOR:

PHONE:

DENTIST: HOSPITAL PREFERRED: PHONE: PHONE:

SPECIAL LIMITATIONS/CONDITIONS/ALLERGIES:

I AGREE TO RELEASE AND HOLD HARMLESS THE ARCHBOLD AREA SCHOOL DISTRICT, ITS EMPLOYEES, ALL COACHES AND ANY AND ALL OTHER OF THEIR AGENTS AND AGREE TO INDEMNIFY EACH OF THEM FROM ANY CLAIMS, COSTS, SUITS, ACTION, JUDGMENT AND EXPENSES ARISING FROM OUR CHILD'S PARTICIPATION IN THE 2024 ARCHBOLD VOLLEYBALL CLINICS.

SIGNATURE:

DATE: