VALLEY CATHOLIC VOLLEYBALL CLINIC

Tuesday May 28th – Thursday May 30th

4:00-5:30

Cost: $60

Valley Catholic Gym

Open to any 2nd-8th grader (girls and boys) who are interested in learning more about the game of volleyball in a fun atmosphere.

Head coach Becky Kemper will be assisted by returning players from the OSAA 4A State Championship team.

Fill out the registration form and mail along with $60 fee to:

Valley Catholic Volleyball Clinic

Becky Kemper

4275 SW 148th Ave.

Beaverton OR 97007

Or, you may email Becky Kemper at bkemper@valleycatholic.org with the name and grade of the participant and then bring the registration and fee to the first day of the clinic.

VALLEY CATHOLIC VOLLEYBALL CLINIC

Registration Form

Player's Name:_____

Parent's Name(s):_____

Address:_____

City:_____ State:_____ Zip:_____

Contact Phone:_____

Email:_____

Alt. Phone(in case of emergency):_____

School:_____

Current Grade: _____

Medical Consent and Insurance

We, the undersigned parents or guardians, hereby grant permission for our daughter, _____ to participate in the Valley Catholic Volleyball Clinic. In consideration of being permitted to use the facilities, I hereby release said Valley Catholic School and its trustees, administrators, and employees from any and all liability for any damage or injury that any participant or my daughter may receive while on the premises of said school, both as to any right of action that may accrue to myself, my heirs and personal representative. This release includes all claims, demands, rights, and causes of whatsoever kind of nature arising from, and by reason of, any and all known and unknown, foreseen and unforeseen bodily and personal injuries, damage to property and the consequences thereof, that hereafter may be sustained.

It is further understood and agreed that, I hereby authorize VALLEY CATHOLIC VOLLEYBALL CLINIC and its employees to secure the necessary services for my child in the event of an accident or illness. Further, I will be solely responsible for the payment of those services.

Parent/Guardian Signature:

_____

The Participant has medical insurance with:_____ Policy #:_____

Family Doctor:_____ Dr. Phone #: _____

List any allergies or pertinent physical conditions: