2017 Terri Spann Volleyball Clinics & Camp

Registration Form and Medical Release Waiver

Athlete's Name: _____Birth Date:_____ HS Graduation_____

Email Address_____

Clinic(s) and/or Camp athlete is participating in:

_____

Total Amount Enclosed $_____

Parent/Guardian Name (Print)_____

Emergency Phone #_____

Primary Insurance Company_____

Name of Policyholder_____

Policy #_____

The above athlete has my permission to participate in training under Terri Spann Volleyball Camps and/or Clinics during the present year of 2017. I verify that the above athlete has been checked by a licensed physician and is physically fit to engage in the activities involved. I certify that the above athlete has full medical insurance with the company listed above. If anything were to happen to the above athlete, I will not hold Terri Spann, Arizona Storm VBC, Terri Spann Volleyball Camps or any other staff member responsible. Nor will I hold the city, school or facility in which the camp/clinic is held at. It will be the parent/guardians responsibility to maintain health insurance for his/her son/daughter throughout the camp/clinic. If my medical information changes during the year of 2017, I acknowledge it is my responsibility to complete a new updated form on all future Terri Spann camps/clinics.

Parent/Guardian Signature_____ Date_____