TREMORS
VOLLEYBALL CLUB

# 2021-2022 PRE-TRYOUT CLINICS
## 15's – 18's DIVISION

| PLAYER INFORMATION | |
|---|---|
| **NAME:** | |
| **AGE:** | **DATE OF BIRTH:** |
| **ADDRESS:** | |
| **CITY:** | **ZIP:** |
| **SCHOOL:** | **GRADE:** |
| **CLUB EXPERIENCE (IF ANY, LIST CURRENT AND PREVIOUS CLUB TEAMS):** | |

**15's – 18's PRE-TRYOUT CLINICS**
**WHERE:** Holy Trinity Gym
**FEE:** $25/player per session, or $35/player for 2-day sessions

- ❑ **15-18's CLINIC** – Wednesday, July 28 at 7:30pm-9:30pm
- ❑ **15-18's CLINIC** – Thursday, July 29 at 7:30pm-9:30pm

| PARENT/GUARDIAN INFORMATION | |
|---|---|
| **NAME:** | |
| **HOME PHONE:** | **CELL PHONE:** |
| **EMAIL:** | |

Please make your **NON-REFUNDABLE** check payable to **SF TREMORS VBC** and mail form and check to
**SF TREMORS VBC**
**P.O. Box 320133**
**San Francisco, CA 94132**

**WAIVER**

I hereby authorize the staff to act for me according to their best judgment in any emergency requiring medical attention and I hereby waive and release SF Tremors Volleyball Club, the coaches and volunteers, from any and all liability for any injuries, illnesses or lost property incurred while at the 2021 Pre-Tryout Clinics. I have no knowledge of any physical impairment that would be affected by the named player's participation in this volleyball program. My signature on this waiver also states that the named player is covered by my personal medical insurance policy. This waiver of liability expressly includes transportation to and from, or in conjunction with the said program.

Player's Signature: _____ Date: _____
Parent/Guardian's Signature: _____ Date: _____