

Academy Christian School

129 W. Border Road. Rock Hill, SC 29730

Phone: 803-327-5673 Fax: 803-327-0212 Email: theacademy@comporium.net

Web: academychristianschool.org

VOLLEYBALL CLINIC REGISTRATION FORM 2021

Players Name: _____ Date of Birth: _____

Parent(s)/Guardian Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Phone: Home _____ Cell _____

Current School Name Attending: _____

Grade entering fall of 2021: _____ Age: _____ Height: _____ Position: _____ Yrs. Played _____

Emergency Contact and number(s) _____

Waiver Statements Medical Release:

All participants must have their own medical coverage. Academy Christian School volleyball clinic provides only excess coverage after your insurance policy has been utilized. Participants will not be allowed to attend the clinic unless the following information is submitted and signed by parent or guardian of the participant.

Academy Christian School Medical Assumption of Risk, Release, and Indemnification Form

Name of Health Care Provider/Group: _____

Health/Medical Insurance Company Phone Number: _____

Policy #: _____ (Please Attach a Copy of Insurance Card: front and back)

Allergies: _____

Reaction to above allergies: _____

Current Medications: _____

List of Chronic Illnesses/Medical Condition: _____

Date of Last Tetanus Shot: _____

List of recent injuries or surgeries:

Have you or anyone in your family been exposed to anyone testing positive for Covid-19 in the pass 30 days? _____ If yes, please explain _____

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Have you or anyone in your family shown any similar symptoms to Covid-19 in the past 30 days? _____ If yes, please explain _____

Do you feel your child is at risk in any way by participating in this volleyball clinic? _____
If yes, please explain _____

The undersigned, being a parent or legal guardian of the child requesting volleyball clinic admittance, does hereby affirm the applicant is physically able to perform activities conducted at the volleyball clinic, and I hereby give my permission for such medical procedures as may be necessary to this participant by Academy Christian School in the event of sickness or injury. I understand that, as a condition of admittance as a participant, the undersigned, on behalf of all parents and guardians, and behalf of the applicant, hereby releases Academy Christian School and all other employees, volunteers or agents of the volleyball clinic from any and all liability, from injury, illness, mental or physical, suffered by the participant during or related to volleyball clinic, to also include transportation and personal property.

***Full payment of \$75 is due with enrollment form to guarantee spot. Any returned checks will be charged an additional \$25 fee. Participants cancelling within 7 days prior to event will be charged 50% of the clinic fees (\$37.50).**

Participant's Signature: _____ Date: _____

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

ACS Staff member's Signature: _____ Date: _____

For office use:

Payment method: cash check other _____

Amount paid: _____ Date: _____ Player approved to play: Y or N