

## South Valley Softball League Wellsville City Girls Fast Pitch Softball

Child's Name:		Grade:	
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Birthdate:		Age as of January 1, 2011	
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Parent/Guardian:			
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Address:			
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City:			
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Home Phone #:			
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Cell #:			
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Work #:			
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I would be interested in _____ Coaching or _____ Assisting my child's team (mark yes or no)
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Shirt size: Circle One	Youth Sizes SM 6-8 M 10-12 L 12-14 XL 14-16	Other sizes please indicate here:
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8 & under:	<b>Fees: 35.00 for all ages</b>	
10 & under:	<b>(\$20 late fee for any registration form turned in after April 2, 2011)</b>	
12 & under:	<b>Make checks payable to:</b>	
14 & under:	<b>Wellsville City Corp.</b>	

Concerns or requests:	
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Emergency contact:	
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Emergency contact phone number:	
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## **Liability Release:**

In consideration of the acceptance of my application for activity with Wellsville Girls Softball League I hereby waive, release and discharge any and all claims for damages for death, personal injury or property damage, which I may have or which may hereafter accrue to me in participation in said event by me or my child. This release is intended to discharge, in advance, Wellsville City, its offices, employees, or agents from liability even though that liability may arise out of negligence or carelessness on the part of the persons or entities mentioned above. It is understood that some recreational activities involve an element of risk or danger or accidents, and knowing those risks, I hereby assume those risks. It is further understood and agreed that this waiver, release and assumption of risk are binding on my heirs and assigns.

## **Parental Consent:**

I give my consent for my child \_\_\_\_\_ to participate in the above activity, and execute the above Liability release on her behalf.

## **Consent to Treat:**

I hereby give my consent to have the above applicant treated by a physician or surgeon in case of sudden illness or accident while participating in the above event. It is understood that Wellsville City provided no medical insurance for such treatment, and the cost thereof will be at my expense.

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Name of Physician

Phone

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Physician's address

\_\_\_\_\_ I do not give my consent to treat and request that medical and surgical services be withheld.

## **Read carefully before signing**

I have read and understand the foregoing registration form, liability release form and parental consent to treat forms, and agree to all of their terms and conditions.

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Signature

Date