

CVP/PHS NE BLUE BLIZZARD CHAMPIONSHIP

FEBRUARY 13TH, 2010

EACH PARTICIPANT MUST HAVE THIS FORM FILLED OUT COMPLETELY. COACHES SHOULD PRESENT THESE AT THE TIME OF REGISTRATION. THIS FORM MAY BE DUPLICATED. NO ONE CAN COMPETE WITHOUT THIS FORM.

SCHOOL OR ORGANIZATION NAME _____

PARTICIPANTS NAME _____ PARENTS NAMES _____

ADDRESS _____ TOWN/CITY _____

STATE/ZIP _____ EMAIL _____

HOME PHONE _____ EMERGENCY PHONE _____ OTHER _____

WHERE CAN A PARENT/GUARDIAN BE REACH DURING THE EVENT? _____

NAME _____ RELATIONSHIP _____ PHONE _____

DOB _____ SCHOOL TEAM (JV, VARSITY, COLLEGE, CO-ED, DANCE)

DOB _____ ALLSTAR TEAM, AGE NOW _____ AGE AS OF 5-31-08 _____

ALL-STAR TEAM MEMBERS, PLEASE LIST ALL TEAMS YOU ARE ON FOR THIS COMPETITION _____, _____, _____

I, _____ (PARENT/GUARDIAN) THE UNDERSIGNED, DO HERBY GRANT PERMISSION FOR MY CHILD _____ TO PARTICPATE IN THE CVP/PHS NE BLUE BLIZZARD CHAMPIONSHIP ON SATURDAY FEBRUARY 13TH, 2010. I ACKNOWLEDGE AND UNDERSTAND THE RISKS INVOLVED FOR THE PARTICIPANT _____ IN THIS EVENT AND ASSUME THOSE RISKS, WHICH MAY BE INJURY, SICKNESS OR EVEN DEATH.

I _____ (PARENT/ GUARDIAN) CONSENT TO THIS PARTICIPATION AND FURTHER CERTIFY THAT I AM ADEQUATELY COVERED BY SCHOOL OR PERSONAL INSURANCE AND AGREE TO HOLD HARMLESS, CENTRAL VALLEY PANTHERS, CVCTC, THEIR COACHES, CHEERLEADERS, AND STAFF FOR ANY INJURY, SICKNESS OR DEATH SUSTAINED AS A RESULT OF MY CHILD _____ PARTICIPATING IN THIS EVENT. I FURTHER AGREE TO HOLD HARMLESS THE XL CENTER OF WHERE THIS EVENT IS TAKING PLACE, ADMINISTRATION, AND STAFF FOR ANY INJURY, SICKNESS, OR DEATH AS A RESULT OF MY CHILD _____ PARTICIPATING IN THIS EVENT.

I _____ (PARENT/GUARDIAN) FURTHER UNDERSTAND THAT A QUALIFIED TRAINER/EMT WILL BE IN ATTENDANCE AT THIS COMPETITION AND WILL ADDRESS ANY MEDICAL NEEDS IN THE EVENT OF AN EMERGENCY OR SICKNESS. I FURTHER AGREE THAT THE TRAINERS JUDGEMENT, FOR FURTHER MEDICAL TREATMENT FOR ANY INJURY MAY BE REQUIRED, AND THAT MY CHILD _____ MAY BE TRANSPORTED TO NEAREST HOSPITAL CLOSEST TO THE EVENT. I _____

ALSO AGREE THAT ALL OF THE INFORMATION LISTED ON THIS FORM IS TRUE, AND IF ANY FALSE INFORMATIONS IS GIVEN, (DOB) THEN THE TEAM(S) MY CHILD IS ON WILL BE DISQUALIFIED FROM THIS CHAMPIONSHIP. NO REFUNDS ARE GIVEN AT ANYTIME DURING THE EVENT.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

PARTICIPANT SIGNATURE _____ DATE _____

MEDICAL INFORMATION

PRIMARY PHYSICIAN _____ PHONE _____

ADDRESS _____ CITY/STATE _____ ZIP _____

PRIMARY INSURANCE _____ NAME OF INSURED _____

EMPLOYER _____ POLICY OR GROUP # _____

ALLERGY/INJURY'S/MEDICATIONS BEING TAKEN,ETC _____