Lancaster Youth Volleyball League

2017 Registration

Name					Home Phone			
Address					City		Zip	
School					Grade 2017/2018			
Parent Information								
Name (Father)					Cell Phone:			
Name (Mother)					Cell Phone:			
Primary Email								
I prefer to be contacted with updates by:	Email		Text		Phone			
Do you have another child in the league?	Yes		No					
If yes what is their name?					Grade:			
How many years has your child played in the league?								
Does your child have any medical conditions?			Yes		No			
If Yes, Please Describe:								
Emergency Contact(Name)					Phone:			

What is your child's T-shirt size?	Youth					Adult					
	XS	S	M	L		S	M	L	XL	2XL	3XL

Are you interested in?	Head Coach		Assistant Coach	

Season Information

Registration Fee: Fall Season (2017) = $75.00

MAKE CHECKS PAYABLE TO: Lancaster Youth Volleyball League, P.O. Box 491, Lancaster, Oh 43130

P.O. Box 491

Lancaster, Ohio 43130

(740) 808-6435

LANCASTERYVL@GMAIL.COM

www.lancasteryouthvolleyball.org

Lancaster Youth Volleyball League

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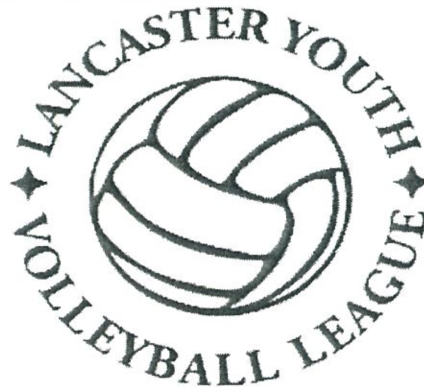
Registration Deadline:	Registration for Fall 2017 season will end on 06/30/2017
Fall 2017 Season Length:	August – October

PARENTAL CONSENT AND RELEASE OF LIABILITY (READ BEFORE SIGNING)

As a parent/guardian of the child listed above, I hereby register my child with the Lancaster Youth Volleyball League and I agree to abide by the rules and regulations of this program. I recognize that playing volleyball includes a risk of injury and I knowingly assume such risk. In consideration of the recreation and training being afforded my child, I release and discharge the LYVL, its sponsors, administrators, coaches and assistants, and all agents and representatives of the above program from all injuries, damages, or loss of property suffered by my child or myself as a result of any game, practice event, or any other person OR as a result of any actions by my child or any other participant in or spectator of said events.

Parental Authorization for Medical Treatment: (initial box 1 to provide consent or box 2 to refuse consent)

	1. In the event that my child needs medical attention and reasonable attempts to contact me have been made unsuccessfully, I hereby give my consent for any treatment deemed necessary by a licensed physician or dentist and the child transferred to any reasonably accessible hospital. This does not cover major surgery unless the opinions of two other licensed physicians or dentist concur on necessity of the surgery prior to its performance.
	2. In the event that my child should require medical attention and all reasonable attempts have been made to contact all listed guardians, I DO NOT give my consent for any medical attention to be given to my child. I request that no action be taken.



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Signature		Print		Date	