DORCHESTER COUNTY T-BALL CLINIC

Registration Form – 2017

All Participants Must Register Every Year

Ages 4 - 6 as of April 1, 2017

REVERSE MUST BE SIGNED

PLEASE PRINT

Childs Name: _____ Date of Birth:_____

Parent/Guardian Name: _____Phone:_____

Address/State/Zip: _____

School: _____Grade:_____

I AM WILLING TO HELP WITH THE FOLLOWING:

ASSISTANT: Yes ___ / No ___

NO REGISTRATION FEE!!!

You must return this form to Dorchester County Recreation and Parks office located at 446 Willis Street. **Registration will be from January 23rd – February 28th.** Registrations received after this date may not be able to participate in this clinic if full. If you have any questions, you may call Dorchester County Recreation and Parks office at 410-228-5578.

DORCHESTER COUNTY T-BALL CLINIC

I/WE, THE PARENT(S), GUARDIAN(S) OR OTHER LEGAL CUSTODIAN(S) OF THE MINOR CHILD WHO WILL PARTICIPATE IN THE DORCHESTER COUNTY T-BALL CLINIC HEREBY CONSENT AND APPROVE THE PARTICIPATION OF SAID CHILD IN ANY AND ALL CLINIC ACTIVITIES DURING THE CURRENT SESSION AND ALL ACTIVITIES IN SUCCEEDING YEARS UNTIL THIS RELEASE IS REVOKED BY ME/US IN WRITING. I/WE ASSUME ALL RISKS AND HAZARDS INCIDENTAL TO THE ACTIVITIES, AND HEREBY WAIVE, RELEASE, ABSOLVE AND AGREE TO HOLD HARMLESS THE DORCHESTER COUNTY RECREATION AND PARKS BOARD MEMBERS AND STAFF, DORCHESTER COUNTY COMMISSSIONERS, ORGANIZERS, SPONSORS, SUPERVISORS, OFFICERS AND DIRECTORS OF THE LEAGUE, FIELD AND FACILITY OWNERS, AND OTHER PARTICIPANTS, AS WELL AS PERSONS TRANSPORTING SAID CHILD.

I/WE UNDERSTAND THAT IT IS THE RESPONSIBILITY OF THE PARENTS OF THE PLAYERS TO MAKE CERTAIN THAT THEIR CHILDREN ARE IN SOUND PHYSICAL CONDITION BEFORE AND DURING THE TIME THEY ENGAGE IN CLINIC PARTICIPATION. I/WE UNDERSTAND THAT IT IS RECOMMENDED THAT ALL CHILDREN WHO PARTICIPATE IN ANY CLINIC ACTIVITY BE EXAMINED BY A PHYSICIAN, TO DETERMINE THERE ARE NO PHYSICAL OR MENTAL DISABILITIES WHICH WOULD IN ANY WAY IMPAIR MY/OUR CHILD'S ABILITY TO FULLY PARTICIPATE IN ANY CLINIC ACTIVITY.

I/WE HEREBY CONSENT AND AGREE THAT IN THE EVENT WE ARE NOT PRESENT, ANY STAFF MEMBER OF THE CLINIC OR VOLUNTEER MAY CONSENT TO EMERGENCY MEDICAL TREATMENT OF MY/OUR CHILD WHICH MAY BE PROVIDED BY ANY LICENSED PHYSICIAN AND/OR ANY HOSPITAL ON MY/OUR BEHALF. A PERSON SO CONSENTING IS HEREBY RELEASED FROM ANY LIABILITY WHATSOEVER WHICH MAY OTHERWISE ARISE AS A RESULT OF CONSENTING TO SUCH TREATMENT. ANY HOSPITAL AND OR PHYSICIAN MAY RELY UPON SUCH CONSENT TO THE SAME EXTENT AS IF ME/US GAVE IT AND SUCH CONSENT REMAINS IN FORCE UNTIL PERSONALLY REVOKED BY ME/US. A PHOTOCOPY OF THIS DOCUMENT SHALL BE ACCEPTED AND HAVE THE SAME FORCE AND EFFECT AS AN ORIGINAL.

I/WE UNDERSTAND THAT MY/OUR SIGNATURE(S) CONSTITUTES MY/OUR AGREEMENT AND CONSENT TO ALL OF THE ABOVE. IT FURTHER CONSTITUTES MY/OUR ACKNOWLEDGEMENT THAT I/WE HAVE READ AND UNDERSTAND ALL OF THE ABOVE AS WELL AS RECEIPT OF NOTICE AND MY/OUR RIGHT TO SEEK LEGAL COUNSEL WITH RESPECT TO ANYTHING CONTAINED HEREIN.

_____ _____

PRINTED NAME OF PARTICIPANT **AGE AS OF APRIL 1, 2017**

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**