



**WINTER VOLLEYBALL ATHLETIC TEAM ROSTER**

TEAM NAME: \_\_\_\_\_ DATE/YEAR: \_\_\_\_\_ COACH: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ E-Mail : \_\_\_\_\_

	<b>PRINT NAME</b>	<b>DOB</b>	<b>ADDRESS</b>	<b>PHONE</b>	<b>^EMAIL</b>
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## Winter Volleyball Liability Waiver

**Please read, then sign this liability waiver and photo release:**

As a participant (the parent/legal guardian of a minor participant), I recognize that there are risks of physical injury, and I agree to assume the full risk of any injuries (including death), losses or damages as a result of participating (allowing the minor for whom I am responsible to participate) in any and all activities described in this release. In consideration of Freeport Park District accepting my registration, I hereby for myself, my heirs, executors, administrators, agree to waive all claims I may have as a result of participating, traveling to and returning from any and all activities of the program against Freeport Park District, its officers, agents, volunteers, servants and employees. I release, indemnify, and hold harmless the Freeport Park District, its officers, agents, volunteers, and employees, from any and all claims from any source or person (including the minor participant) for injuries (including death), losses, expenses, or damages due to the participation herein requested and granted, as well as the traveling to and returning from the identified activities, or losses arising out of, connected with, or any way associated with the activities herein described.

I understand that I or my child/ward may be photographed or videotaped while participating in the above program(s). I give my permissions for photos and videotape of me or my child/ward to be used to promote the Park District and that such photos and videos will be the property of the Freeport Park District.

In the event of an emergency, I authorize Freeport Park District to secure medical treatment deemed necessary for my immediate care and/or the care of my child and I agree that I will be responsible for the payment of any and all medical treatment and services rendered.

PARTICIPANTS/PARENT SIGNATURE                      DATE

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PARTICIPANTS/PARENT SIGNATURE                      DATE

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Team Coaches Verifications: Team Name: \_\_\_\_\_ Coaches signature: \_\_\_\_\_ Date: \_\_\_\_\_

This is to certify that the release form has been signed by each player on the team roster.