FLIGHT VOLLEYBALL CENTER MEDICAL RELEASE AND WAIVER

PLEASE PRINT CLEARLY, COMPLETE ALL QUESTIONS, READ CAREFULLY, AND SIGN AT THE BOTTOM.

PARTICIPANT'S NAME ________________________________ DATE OF BIRTH __________________

PARTICIPANT'S PARENTS (IF PARTICIPANT IS UNDER 18): ______________________________________

MAILING ADDRESS: ____

HOME PHONE: ______________________ CELL PHONE:___________________________________

PARENT'S EMAIL ADDRESS: ____

SPORT/LEAGUE: _______________ CLUB/TEAM NAME: ___________________________________

COACH/DIRECTORS/MANAGERS NAME: ________________________PHONE: ______________________

Parent acknowledges that: (1) Participant is less than 18 years old, (2) Flight Volleyball Center is only providing Participant an opportunity to use its facility for recreational use, (3) Participant's use of the facility is voluntary, (4) there are inherent risks in the games, activities and sports that participant may play at the facility including but not limited to serious bodily injury, (5) Participant is familiar with the rules of the games, sports and activities to be played at the facility, and (6) we have carefully read, understood and accept all policies of Flight Volleyball Center, which are posted in the facility, copies of which we can request at any time.

In consideration for Participant's privilege to use this facility, Parent agrees on his/her behalf and on behalf of Participant to: (1) to assume all risks of use of the facility, (2) defend, indemnify and hold harmless Flight Volleyball Center, its owners and the owners of the facility, its employees, agents, and all others having an interest in the facility from any injury, liability, negligence, cause of action, claim, and damage of every kind which may arise from Participant's use of and participation in activities at the facility, (3) permit the Coach/Team Manager and Flight Volleyball Center to obtain medical treatment for Participant in the event of injury or sickness, and (4) reimburse Flight Volleyball Center for any medical treatment provided to Participant. Any health care insurance, which covers Participant shall be the primary insurance coverage for any medical treatment.

Name of Parent (please print)_______________________________________

Name of Participant (please print)____________________________________

X____Date________________
Signature of Participant –or- Parent if (participant is under 18)

***Parent Contact Information in case of emergency**

Name # 1______________________________ Phone ______________________________

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