



# Contact Information

•CLUB•ARROWHEAD•VOLLEYBALL•

Name		Address/City/Zip:			
Home Phone#		Player's Cell#		Age	D.O.B.
School Name		Grade	H.S. Graduating Year	Referred By:	
Players Email		Previous Club/Team		Parents Email	
Parents Name		Parents Wk Phone #		Parents Cell#	

## MEDICAL/LIABILITY RELEASE FORM

I (We) \_\_\_\_\_ the legal guardian of \_\_\_\_\_ authorize Club Arrowhead, Inc. and all those associated with Club Arrowhead Inc. to administer general first aid treatment for any injury sustained is life threatening, or in need of emergency treatment. I authorize Club Arrowhead, Inc. or its representatives to summon any or all-professional emergency personnel to attend, transport and treat my child.

If the injury sustained requires hospitalization, I understand that I or my medical insurance company is solely responsible for all bills and claims that may be filed as a result of an injury.

By signing this medical release and liability form, I understand that I will not hold Club Arrowhead, Inc. or its representatives responsible for any injury sustained to my child or for any other reason while my daughter is participating in tryouts or regular season play.

X \_\_\_\_\_ Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_