PLAYER REGISTRATION FORM

Circle program choice below;

Spring Clinics 1- 2 or 3 / Summer 1- 2 or 3 / Summer Girls F/JV League
Sum MS League / Fall Jr Team League / Fall MS League
Winter MS League / Winter HS League

TEAM NAME: _____ (Optional) **DATE:** _____

ATHLETE NAME: _____ **GRADE:** _____ **AGE:** _____ **SHIRT SIZE:** _____

Any Allergies / special instructions? _____

Skill Level: Beginner / Intermediate / Advanced Are you new to CRUSH? Yes / No

How did you hear of/ who introduced you to CRUSH VB? _____ **(Referral / Rewards Program)**

Parent / Guardian Name: _____

Address: _____ **City:** _____

Home Phone: _____ **Emergency Phone:** _____

E-Mail Address: _____

WITH MY SIGNATURE BELOW, I CERTIFY THAT MY CHILD HAS HAD A PHYSICAL BY A LICENSED DOCTOR WITHIN THE LAST 12 MONTHS & IS CLEARED TO PARTICIPATE IN ALL ACTIVITIES OF CRUSH VB LLC. I HEARBY WAIVE & RELEASE CRUSH VB LLC & STAFF FROM ANY & ALL LIABILITY FROM INJURIES TO MY CHILD

Parent / Guardian Signature: _____

Thank You,

Please mail form with Payment or min. deposit $50, to;

CRUSH VOLLEYBALL LLC

PO Box 702, Clark, NJ 07066