

FWSA CLINIC REGISTRATION FORM

NAME:

STREET:

CITY/STATE/ZIP:

BIRTHDATE:

PHONE:

EMAIL:

I agree that I am participating in FWSA practices, games and other activities at my own risk. In consideration of my participation in these events, I assume all risk of injury and I release FWSA coaches, officers, agents, and game referees from all liability and agree not to sue for injuries to myself or damage to or loss of my property. I agree to conduct myself in a sportswoman like manner and to follow the rules established by FWSA.

Signature

Date signed