**ALC 2018 Summer Skills Clinics Registration Form**

**Please e-mail complete form to Doug Melton at** doug.melton@baml.com**.**

**ATHLETE INFORMATION**

* Player Last Name:
* Player First Name:
* Birthday (mm/dd/yy):
* Age as of May 1, 2018:
* 2018-2019 Academic Grade:
* Position:
* Height:
* Weight:
* US Lacrosse Number:
* Home Address:
	+ Address 1
	+ Address 2
	+ City
	+ State
	+ Zip
* Home Phone Number:
* Player Email Address:

**PARENT/GUARDIAN INFORMATION**

* Parent #1 First Name:
* Parent #1 Last Name:
* Parent #1 Email Address:
* Parent #1 Cell Phone Number:
* Parent #2 First Name:
* Parent #2 Last Name:
* Parent #2 Email Address:
* Parent #2 Cell Phone Number:

**INSURANCE & EMERGENCY CONTACT INFORMATION:**

* Insurance Company:
* Primary Policy Holder’s Name:
* Group Number:
* Policy Number or ID:
* Emergency Contact Name:
* Phone Number:
* Relationship:

**RELEASE OF LIABILITY** (please read carefully)

As a participant, or parent / guardian of a participant in an Alpharetta Lacrosse Club activity, program, camp, clinic, or team, I recognize and acknowledge that there are certain risks of physical injury associated with the sport of lacrosse and I agree to assume the full risk and liability for any injuries (including death), damage, or loss which I or my minor child may sustain as a result of participating in any and all activities connected-to or associated-with the Alpharetta Lacrosse Club. I agree to waive and relinquish all claims I or my child may have against the Alpharetta Lacrosse Club, its members, supporters, sponsors, volunteers, staff, Officers, Board of Directors, and Coaches, as well as Alpharetta High School, Alpharetta High School Men’s Lacrosse, and the Alpharetta High School Booster Club as a result of participating in any and all activities connected-to or associated-with the Alpharetta Lacrosse Club. I further agree and represent that the participant has been examined by a physician and is physically fit and able to participate in lacrosse activities. I also give permission to have my child treated by a physician if necessary.

* Signed By: (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_