



# RENEGADES LACROSSE

P.O. Box 144, Croton Falls, NY 10519 914.720.6832

## 2010 RENEGADES SUMMER SELECT TEAM

Player Name \_\_\_\_\_  
Position \_\_\_\_\_ Grade Entering Fall 2010 \_\_\_\_\_  
Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Parents' Names \_\_\_\_\_  
Email \_\_\_\_\_  
Emergency Phone Number (cell) \_\_\_\_\_  
US Lacrosse # \_\_\_\_\_  
Primary Health Insurance Provider: \_\_\_\_\_  
Policy Number: \_\_\_\_\_

Sizes (Adult S M L XL): T-shirt \_\_\_\_\_ Sweatshirt \_\_\_\_\_ Shorts \_\_\_\_\_

I give my son, \_\_\_\_\_ permission to participate in the Renegades Lacrosse program. In signing this application, I waive, discharge, release and covenant not to sue Renegades Lacrosse, Inc. their respective members, administrators, directors, agents, coaches and other volunteers or other participants (collectively, the "Released Parties") from all claims, demands, losses and damages on the account of any injury, including damage to property or death, caused or alleged to be caused in whole or in part by the negligence of the Released Parties or otherwise. I understand that, by participating in this sport, injury and/or death may occur and I knowingly assume all risks associated with my son's participation, even if arising from the negligence of the any of the Released Parties or others, and I assume FULL responsibility for my son's participation. I certify that my son is in good physical condition and can participate in the Renegades Lacrosse program. I understand that my son will be covered by my own family insurance and may be eligible for supplemental insurance with his US Lacrosse membership. Further, I hereby authorize the staff of Renegades Lacrosse, to provide medical attention, but I acknowledge that they are not required or obligated to do same, should my child require it. Such medical attention includes, but is not limited to, prevention (i.e. taping, stretching), assessment, management, and referral to an appropriate medical facility. I also grant permission for an emergency room physician to examine and manage, hospitalize or secure treatment, for my child in the event of an emergency.

Photo Release: I grant to Renegade Lacrosse, Inc. my consent and permission to use my son's photograph for any advertising or media purposes.

Refund Policy: A full refund will be given if cancelation is made by January 1<sup>st</sup>. A 50% refund will be given if cancelation is made by March 1<sup>st</sup>. After March 1<sup>st</sup>, there are no refunds. In case of injury, monies can be applied to any future Renegade programs or a 50% refund will be given.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Amount Paid \_\_\_\_\_ Check # \_\_\_\_\_

Mail check to: Renegade Lacrosse, Inc., P.O. Box 144, Croton Falls, NY 10519