RENEGADES LACROSSE

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

Renegade Indoor Lacrosse Program
@ Brewster Sports Center
Nov. 8th – Dec. 20th
7-8pm
Fee $175

NAME ________________________________ **DOB** _____________
POSITION _________________________ **GRADE** ______________
ADDRESS ____
TEL# ______________________ **CELL#** ______________________
US LACROSSE # ____
E-MAIL _________________________ **@** ____________________
THIS EMAIL ADDRESS WILL BE USED TO CONFIRM YOUR REGISTRATION – PLEASE WRITE LEGIBLY

LIST ANY MEDICAL PROBLEMS ON BACK OF FORM
Mail registration form and check to:
Renegade Lacrosse
P.O. Box 144,
Croton Falls, NY 10519

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.

Parent Signature ________________________________ Date _______________

Amount Paid _____________ Check # ______________