

# RENEGADES LACROSSE

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

## RENEGADE LACROSSE & THE NORTH SALEM RECREATION DEPARTMENT GIRLS SUNDAY MORNING LACROSSE CLINIC Grades 5th thru 10<sup>th</sup>

*All players will receive a t-shirt, tank top, and bumper sticker*

**DATES:** Sundays, September 18<sup>th</sup> thru October 23<sup>rd</sup> (Rain date: October 30<sup>th</sup>)

**TIME:** 9:00 – 11:00am

**LOCATION:** Joe Bohrdrum Park, North Salem, NY  
Exit 8 off 684 North. Only 25 minutes from White Plains

**COST: \$250 Make check payable to: North Salem Recreation Department**  
Mail check and form to: Renegade Lacrosse, Inc. PO Box 144, Croton Falls, NY 10519

*For further information contact Coach Curran at [bcurran7@optonline.net](mailto:bcurran7@optonline.net)*

PLAYER NAME \_\_\_\_\_  
POSITION \_\_\_\_\_ GRADE \_\_\_\_\_ T-SHIRT SIZE \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
TEL# \_\_\_\_\_ CELL# \_\_\_\_\_  
US LACROSSE # \_\_\_\_\_  
E-MAIL \_\_\_\_\_

**Please write legibly.  
This will be used for confirmation of registration.**

HEALTH INSURANCE PROVIDER \_\_\_\_\_  
POLICY NUMBER \_\_\_\_\_

**LIST ANY MEDICAL PROBLEMS ON BACK OF FORM**

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_

**Waiver:** I hereby release the Town of North Salem and Renegade Lacrosse, Inc., their officials, employees, and volunteers of any liability whatsoever in connection with any damages and/or injuries that my child may sustain as a result of participating in the programs of the Town of North Salem and Renegade Lacrosse, Inc. All participate at their own risk. The Town of North Salem and Renegade Lacrosse, Inc. do not carry insurance to cover hospitalization or medical costs of persons injured while participating in any athletic program. 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.