

RHODE ISLAND VOLLEYBALL | JANUARY SKILLS CLINICS

The University of Rhode Island Women's Volleyball program will be hosting a series of volleyball skills clinics in January 2019. Our clinics will place a premium on learning and applying the skills of volleyball. Our staff will teach, demonstrate, and provide important feedback to help athletes improve technique and skill level. Our sessions are open to athletes in the **7th through 12th grade** and you can attend as many or as few sessions as you would like in January. Each session will be \$25.00, and **space is limited to 20 athletes per time slot each night**. Our Wednesday sessions will primarily focus on SETTERS & HITTERS (MH, OH, & RS). Our Monday & Thursday sessions will focus on all skills and be able to accommodate players in any positions.

To reserve a spot in any of our sessions complete this form, checking the boxes of the sessions you will be attending and return the form with your check (Payable To: RHODE ISLAND VOLLEYBALL) to our office: **Rhode Island Women's Volleyball Office, 75 Keaney Rd. Kingston, RI 02881**

Please contact: Coach Iain McCoy (iainmccoy@uri.edu) with any questions.

APPLICANT INFORMATION

First Name:		Last Name:	
City:		State:	
		ZIP Code:	
Email:	<i>All event communication will be sent to this email address!!!</i>		
School:		Grade:	
		Club Team:	

INTERMEDIATE CLINIC SESSIONS: 5:00 – 6:30 pm

*** Clinic sessions are designed for players who have less than 2 years of experience with volleyball ***

<u>Week 1:</u>		Wednesday January 2nd	<input type="checkbox"/>	Thursday January 3rd	<input type="checkbox"/>
<u>Week 2:</u>	Monday January 7th	<input type="checkbox"/>	Wednesday January 9th	<input type="checkbox"/>	Thursday January 10th
<u>Week 3:</u>	Monday January 14th	<input type="checkbox"/>	Wednesday January 16th	<input type="checkbox"/>	Thursday January 17th
<u>Week 4:</u>	Monday January 21st	<input type="checkbox"/>	Wednesday January 23rd	<input type="checkbox"/>	
Number of sessions:		X	\$25.00	=	Check Number:

ADVANCED CLINIC SESSIONS: 6:30 – 8:00 pm

*** Clinic sessions are designed for players who have 2 years or more of experience playing volleyball ***

<u>Week 1:</u>		Wednesday January 2nd	<input type="checkbox"/>	Thursday January 3rd	<input type="checkbox"/>
<u>Week 2:</u>	Monday January 7th	<input type="checkbox"/>	Wednesday January 9th	<input type="checkbox"/>	Thursday January 10th
<u>Week 3:</u>	Monday January 14th	<input type="checkbox"/>	Wednesday January 16th	<input type="checkbox"/>	Thursday January 17th
<u>Week 4:</u>	Monday January 21st	<input type="checkbox"/>	Wednesday January 23rd	<input type="checkbox"/>	
Number of sessions:		X	\$25.00	=	Check Number:

***** PLEASE COMPLETE AND RETURN THE MINOR CONSENT & RELEASE FORM *****

RHODE ISLAND VOLLEYBALL WINTER CLINICS

Minor Consent & Release Form

RHODE ISLAND VOLLEYBALL WINTER CLINICS

Minor Consent & Release Form

I hereby certify and agree that _____ (Child's Name) (hereinafter, "My Child") has my approval to participate in the **RHODE ISLAND VOLLEYBALL WINTER CLINICS** (hereinafter "the Activity") to be held from **January 2rd, 2019 through January 23rd, 2019**, at the University of Rhode Island.

In return for My Child's participation in the Activity: I fully and forever RELEASE, WAIVE, DISCHARGE, ACQUIT, INDEMNIFY, HOLD HARMLESS and COVENANT NOT TO SUE, University of Rhode Island, Rhode Island Board of Education and the State of Rhode Island including its governing board, officers, employees, students, agents and volunteers (hereinafter collectively referred to as "the University") from any and all liabilities, claims, or injuries, including death, that may be sustained while participating in this activity, including but not limited to travel to, from, and for the activity, or while on premises owned or controlled by the University. I understand this release does not apply to injuries caused by intentional or grossly negligent conduct on the part of the University. I further agree to indemnify and hold harmless the University for any loss, liability, claim or injury caused by me (my child) while participating in this activity including traveling to, from, and for the activity, or while on premises owned or controlled by the University.

I recognize that the University does not assume responsibility for or liability for - including costs and attorney's fees - any accident or injury or damage resulting from any aspect of participation in the Activity. The University is not liable for any special, incidental or consequential damages arising out of or in connection with any aspect of participation in the Activity.

I also give permission for My Child to receive any emergency medical treatment by a healthcare professional, including emergency medical transportation, which may be required for injuries sustained by My Child. However, I agree that the University (including, but not limited to, each of the University's regents, boards, agents, employees, officers or representatives) are not responsible for any medical bill incurred as a result of any personal illness or injury to My Child, even if the University has signed hospital documentation promising to pay for the treatment. That medical bill is my responsibility.

I understand that by signing this document, I give up substantial rights that I or My Child would have otherwise to receive damages for any loss occasioned by the University's fault, and I sign it voluntarily and without inducement.

THIS IS A WAIVER OF LEGAL RIGHTS. PLEASE READ AND UNDERSTAND BEFORE SIGNING.

Signature of Parent/guardian

Date

Daytime Phone (Parent/guardian)

Medical Insurance Company: _____

Policy Number: _____

Name of Primary Policy Holder: _____

Emergency Contact Name & Phone: _____