f		_ Participant Name_ Participant Grade		
t				
h		_ rarticipant Date 0	4 BITUL	
		Participant Phone		
		Participant Addre		
		(include zip code)		
Catho	lic Schools Rele	ase and Authorizatio	n to Participate	e Form
I,	, aı	n the parent and/or authorize	ed Guardian of	
(Name	e)			(Participant)
I hereby authorize		, date of birth		, to participate
	(Participant)	(Partic	pipant's Date of Birth	ı)
the	Program at		during the	school year.
(Sport/Activity			(Yea	
I am aware that there a	are certain risks of ini	ury inherent in participation	in	
	j	, , , , , , , , , , , , , , , , , , ,	(Sport/Act	
Namethalana Taindinid	lucilly and an habalf a	f was and day abten benchrou		
	50	f my son/daughter, hereby r		
(Name of School	) (N	lame of Coach/Moderator)	(Name of As	st. Coach/Moderator)
a	and/or assigns from ar	ny and all claims, actions, de	bts, damages, costs,	loss of service, expendence
their heirs, executors a				
	atever, in law or in ec	uity, which may hereafter a	ccrue from or arise of	out of
and compensation, wh		quity, which may hereafter a	ccrue from or arise c	out of(Participant)
and compensation, wh			ccrue from or arise c	ut of(Participant)
			ccrue from or arise c	ut of(Participant)
and compensation, wh participation in	(Sport/Activity)			(Participant)
and compensation, wh participation in I authorize the coachin	(Sport/Activity) ng staff to provide em	*	of any injury to or ill	(Participant) ness by my child if
and compensation, wh participation in I authorize the coachin qualified medical pers	(Sport/Activity) ng staff to provide em connel consider treatm	ergency medical treatment of	of any injury to or ill orize any qualified, l	(Participant) ness by my child if icensed physician to e of
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and compensation, wh participation in I authorize the coachin qualified medical pers render medical treatme Insurance Informatio	(Sport/Activity) ng staff to provide em connel consider treatm ent which in his or he	ergency medical treatment of ent necessary. I further auth r judgement may be deemed	of any injury to or ill orize any qualified, l necessary in the car	(Participant) ness by my child if icensed physician to e of
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and compensation, wh participation in I authorize the coachin qualified medical pers render medical treatment Insurance Information Subscriber: Policy Number: Pre-existing Medical Construction In witness whereof, I se	(Sport/Activity) ng staff to provide em connel consider treatm ent which in his or he on: Conditions: sign this form on the	ergency medical treatment of ent necessary. I further auth r judgement may be deemed Group Nun Company: day of	of any injury to or ille orize any qualified, l necessary in the car nber:	(Participant) ness by my child if icensed physician to e of (Participant)

## **SMS Little Dribblers**

## for PreK-Grade 8!



## Fridays starting on March 17 2:30-3:30pm

## Attached form must be completed to participate Pick Up is from the BACK DOOR of Lateran Hall at 3:30pm Coaches: Doug Dorio, Erica Dorio, and Natalie Endicott

Change of clothes is OPTIONAL! Bring a water bottle!