Brotherhood Lacrosse

Winter Clinic Registration -
Offense & Defense Skill Clinic

Brotherhood Lacrosse LLC
PO Box 82
Midland Park NJ, 07432

Player Name______________________________________ Position__________________

Address______________________________ City____________________ State _____________

Zip Code____________ D.O.B_______________ Parents Name's _______________________________

Phone Number______________________ Emergency Contact Name__________________________

Emergency Phone Number_______________________ Current Grade (2011-12 School Year)________________________

Health Insurance Carrier_______________________ Insurance Number______________________________

Email Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
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US Lacrosse Number ☐☐☐☐☐☐☐☐☐☐☐☐

ETA Winter 2012

Offense & Defense Skill Clinic
Winter Session
Thursday Nights

1/12, 1/19, 1/26, 2/2, 2/9, 2/16
6-7 pm

Payment Information-
$240 (For 6 week session)

Please make all Checks Payable to:
Brotherhood Lacrosse LLC

My son, ____________________, has requested to participate in a Brotherhood Lacrosse activity/event. I am fully and completely aware of the actual potential risks inherent in this activity. By signing below I am asserting that we knowingly and voluntarily assume all such risks. I further assert that my son is covered by a health/accident insurance plan, which will be available to cover the costs of any medical expenses incurred should he be injured in the course of participating. I agree not to hold Brotherhood Lacrosse LLC, its directors, coaches, or other participants, liable for insuring any losses we suffer in relation to our son's participation. I understand that Brotherhood Lacrosse LLC does not maintain liability insurance coverage associated with lacrosse activities or events. I assume full and complete responsibility for obtaining proper health/accident insurance coverage.
I hereby authorize the Staff of Brotherhood Lacrosse LLC to provide medical attention should my child require it. Such medical attention includes, but is not limited, prevention, 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.

________________________	________________________	________________________	____________
Signature of Legal Guardian	Printed Name of Legal Guardian	Printed Name of Participant	Date

Mail the following Items with your Registration Form to the address listed below:
*** One check payable to "Brotherhood Lacrosse LLC" ***
*** Photocopy of Primary Insurance Card ***
*** Photocopy of US Lacrosse Card ***

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