

POST 320 BASEBALL HITTING/FIELDING/PITCHING SESSIONS

Registration Form

Name _____ Age _____

Street Address _____ City _____ State ____ Zip _____

Parent(s) Name _____ Phone # _____

Emergency Contact Person _____ Phone # _____

Email(s) _____

Session 1 (Hitting) _____

Session 2 (Fielding) _____

Session 3 (Pitching) _____

Amount Paid _____

*Please check all that apply

I understand that Post 320 will not be held responsible for injuries or loss of property while my child is attending the baseball clinic/lessons. I authorize the director and staff to act for me in an emergency requiring medical attention. My child is medically fit to participate in all activities involved in the baseball clinic/lessons.

(parent's signature)

(date)