

Chambersburg Recreation Department Lacrosse Clinic

Participant's Name _____ M _____ F _____ Grade _____ DOB _____ Age _____

Email Address _____ Phone _____

Address _____ City _____ Zip _____

Please Circle Township in which you reside: Boro Greene Guilford Hamilton Letterkenny Lurgan Other

Parent or Guardian Name: _____ Phone: _____

Are there any medical conditions or medications of which we should be aware? If yes, please explain.

Waiver / Permission Slip

This form grants _____ (participant's name) permission to participate in the Chambersburg Recreation Department's Lacrosse Clinic. I am aware that this type of recreational activity may result in injury. I (we) agree that the Borough of Chambersburg, its representatives and/or other organizations and individuals connected with sponsoring or conducting this event will not be held liable for any injury that may occur.

Parent or Guardian Signature _____ Date _____

Photo Release

I, _____, give my permission to the Chambersburg Recreation Department to use photographs of my child or myself for the purpose of advertising and promotion.

Parent or Guardian Signature _____ Date _____

	<u>Day:</u>	<u>Date:</u>	<u>Time:</u>	<u>Reg. Deadline</u>
Co-ed, Indoor Lacrosse Clinic				
1 st -4 th Grade	Sunday	10/7-28	1:00-2:00 PM	9/28
5 th -8 th Grade	Sunday	10/7-28	2:00-3:00 PM	9/28

Cost for each Session: \$29 / \$25 Borough Resident _____ # of session(s) x \$ _____ = \$ _____

Return Form with Payment to: Chambersburg Recreation Department
235 S. 3rd St., Chambersburg, PA 17201