

# Williamsburg Recreation Center Youth Volleyball Clinic

PO Box 596  
Williamsburg, Ia 52361  
(319)668-1636  
[rec@iowatelecom.net](mailto:rec@iowatelecom.net)

## 4<sup>th</sup> -6<sup>th</sup> Grade

March 10<sup>th</sup>, 17<sup>th</sup>, 24<sup>th</sup> and 31<sup>st</sup>

Saturday Mornings

9:30-11am

Cost: \$25.00

**Deadline for sign up is Monday, March 5, 2012**

Fill out the registration form below and return to the Williamsburg Community Recreation Center.

CHILD'S NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_

PARENT'S NAME \_\_\_\_\_ GRADE LEVEL \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

Clinic Fee- \$25.00

Make check payable to: WCRC

The cost is includes a t-shirt, please circle size.

**Youth:** SM MD LG

**Adult:** SM MD LG

Please fill out back of form.

THIS MUST BE COMPLETED AND SIGNED BEFORE YOUR CHILD MAY PARTICIPATE.

EMERGENCY TREATMENT RELEASE FORM

PARTICIPANT'S NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PARENT'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ TOWN \_\_\_\_\_ ZIP \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ CITY \_\_\_\_\_ PHONE \_\_\_\_\_

SPECIFIC MEDICAL ALLERGIES, CHRONIC ILLNESS OR OTHER CONDITIONS:  
\_\_\_\_\_

OTHER LOCAL CONTACT IN CASE OF EMERGENCY:

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ PHONE \_\_\_\_\_



As a parent and/or guardian, I do hereby give my permission to an authorized representative of the Williamsburg Recreation Department to obtain professional medical attention for my child in case of injury or illness; if I can not be located. I understand that I AM responsible for all cost involved.

I do hereby authorize treatment by a qualified and licensed physician of the following minor in the event of a medical emergency which, in the opinion of the attending physician, is delayed. This authority is granted only after a reasonable effort has been made to reach me.

NAME OF MINOR CHILD \_\_\_\_\_

THIS RELEASE FROM IS COMPLETED AND SIGNED OF MY OWN FREE WILL WITH THE SOLE PURPOSE OF AUTHORIZING MEDICAL TREATMENT UNDER MEDICAL EMERGENCY CIRCUMSTANCES IN MY ABSENCE.

SIGNED \_\_\_\_\_  
RELATIONSHIP-CIRCLE ONE: FATHER MOTHER LEGAL GUARDIAN