

Co-ed Sand Volleyball

SUMMER CO-ED TEAMS FORMING!

East Valley Catholic Parishes are inviting teams to play volleyball this summer.

June 3-July 1, 2009

3 levels- jr. high, high school and Young Adult

DETAILS:

Wednesday evenings starting June 3 at Seton (Approximate Time)

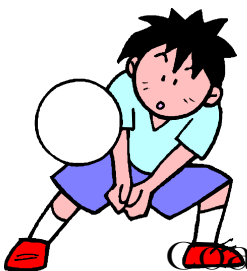
Jr. high- incoming 6-through incoming 8- plays 6-7 pm

High school- incoming 9th through incoming 12th- plays 7-8 pm

Young adult- 18-35 yrs- plays from 9-10 pm



- Jr. High & High School Teams consist of up to 12 players-
 - (4 players —must be the opposite gender)
- Young Adult Teams will be playing fours -(may have up 8 people on a team)
 - Young Adults may form their own teams or sign up to be placed on a team



Join Team St. Andrew's!

\$20 each—have shirt

\$30 each— need shirt

ALL REGISTRATIONS ARE DUE BY May 13th.

Coaches meeting. 5/12- St. Andrew's teen center, 7pm
go to the website for all the details:

Name _____ Parish _____

Category Jr. H ___ HS ___ YA ___ email: _____

Address _____

Home phone _____ Cell phone _____

St. Andrew's Team _____ St A team shirt size (if purchasing) _____

Independent Team _____ Team Name _____

***** Money due at time of registration *****

Release and Consent Form

(**Young Adults-Please fill out what applies to you)

Please print or type all information.

Participant's Name: _____

Street Address: _____ City _____ Zip: _____

Sex: Male / Female Age: _____ Birth-date: _____ Grade **2009-2010**: _____

Father's/Guardian full name: _____ Work Phone: _____

Mother's/Guardian full name: _____ Work Phone: _____

Parent's Home Phone: _____ Cell Phone: _____

Parent Email (if under 18): _____

Participant Email: _____

Medical and Allergy History (Check all that apply)

_____ Hay Fever _____ Asthma _____ Allergy to Sulfa drugs
_____ Fainting _____ Allergy to Bee Stings _____ Allergy to Penicillin
_____ Convulsions _____ Reaction to Poison Ivy/Oak
_____ Allergy to other drugs/medications _____
_____ Allergy to Food items _____

Special Medication, Illnesses or conditions we should know about:

I here by authorize a responsible adult to dispense to my child, if needed only the following that are initialed by a parent/guardian. (Please initial all that apply):

_____ Aspirin _____ Tylenol _____ Advil _____ Ibuprofen
_____ Pepto-Bismol _____ Benadryl _____ Topical Antiseptic
_____ Prescription: _____

Immunization and Physician Information

Tetanus Booster: _____ Yes _____ No Date: _____
Name of Family Physician/Clinic: _____ Phone: _____
City: _____ Insurance Company: _____
Card #: _____ Group #: _____

In case of emergency when parents can not be reached, who is the nearest relative/friend:

Name: _____ Relationship: _____ Phone: _____

Participant Signature: _____

Parent/Guardian Signature: _____