TWIN CITY BASEBALL & SOFTBALL CLUB

Baseball Clinic Registration Form

YOUTH PLAYER INFORMATION

Last Name		First		M.I.	DOB:
Street Address				Apartment/Unit #	
City		State		ZIP	
Phone		E-mail Address			
Sex (M/F):	Bat (R/L):		Throw (R/L):		
Defensive Positions:					
Do you play in a recreational league?	YES	NO	If yes, what league?		
Do you play for a travel team?	YES	NO	If yes, what travel team?		

CLINIC REGISTRATION

Fall Clinic : Check box Fielding and Throwing Session ☐ Hitting Session ☐	Starting November 8th or 9th (Nothing on Thanksgiving week) Finishing December 20th or 21st	Total $100 Each Session
Fielding and Throwing : Saturdays	Hitting Session : Sundays	

Make Check Payable to: **Twin City Baseball & Softball Club**

Check Number:

Check Amount:

Mail Check and Form to:

Twin City Baseball and Softball Club

3905 M-139, Suite # 107

St. Joseph, Michigan 49085

CONSENT FOR MEDICAL TREATMENT & LIABILITY RELEASE

I verify that my son/daughter has been checked by a licensed physician and is physically able to participate in this Sports Camp/Clinic. As the Parent or Legal Guardian of the above named player, I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions necessary to preserve the life, limb, or well-being of my dependent.

The undersigned does hereby agree to hold harmless and indemnify Twin City Baseball & Softball Club LLC, their officers, agents, coaches, assistants and employees, from any and all liability, loss, damages, costs, or expenses which are sustained, incurred, or required arising out of the actions of my son/daughter in the course of the camp/clinic.

Parent or Legal Guardian Signature:____

Players Name:____

Date:_______/___________/________