

***2010 H.C.I. Holiday Camp
Reservation and Medical Release***

Camper's Name _____

Age _____

Grade _____

Position _____

Shirt Size _____

Father's Name _____

Mother's Name _____

Full Address _____

Email Address _____

Home Phone # _____

Cell # _____

I/we are/am the parents and/or legal guardian(s) of the above listed child, and I/we hereby understand and agree as follows:

1. Participation in the H.C.I. Holiday camp requires the ability to run, throw, swing a bat, and catch a ball. Additionally, participation requires the capacity to understand and take direction from instructors and chaperones.

Does your child have any current condition that limits his ability to participate in these activities? NO YES (circle one)

If "yes" please explain

Please provide information about allergies and medical conditions that The Hitter's Club staff should know in the case of an emergency. _____

2. I/we know that my/our child's participation in the H.C.I. Holiday camp activities may result in serious injuries and protective equipment does not prevent all injuries to players.

I/we do hereby waive, release, absolve, indemnify, and agree to hold harmless Hitter's Club, Inc., its staff, organizers, shareholders, directors, coaches, employees, sponsors, participants, from any claims arising out of any injury to my/our child whether the result of negligence or any other cause except to the extent and in the amount covered by accident or liability insurance.

3. I/we give my/our approval for my/our child to participate in any and all H.C. I. Holiday Camp activities.
4. I/we understand that all softball equipment and all personal belongings are the sole responsibility of each camper.
5. I/we hereby notify Hitter's Club, Inc. officials of the following information that is relevant to my/our child's ability to participate in the H.C.I. Holiday Camp.

In case of emergency, I/we hereby authorize our family physician to treat our child. In case of emergency, if our family physician cannot be reached, I/we hereby authorize our child to be treated by another qualified, licensed physician who is then available.

Family Physician _____ Phone _____

Health Insurance Plan _____ Allergies _____

Date of last Tetanus booster _____

Parent(s) or Guardian(s) Signature _____ Date _____

Parent(s) or Guardian(s) Signature _____ Date _____

Please enclose these forms and your payment of \$160.00 made payable to Hitter's Club Inc.

Mail to:
Hitter's Club
P.O.Box 80913
Billings, MT 59108