



Presents:

THE CRYSTL BUSTOS HITTING CLINIC

Saturday, October 11, 2014

**Bristol Town Beach Sports Complex
Asylum Rd. Bristol, RI 02809**

8U – 12U: (9:00am – 12:00pm)

13U – 18U: (1:00pm – 4:00pm)

****Autograph Session 12:00pm to 1:00pm for Participants Only.**

Player Name: _____ Age: _____

Address: _____

Parent/Guardian Name: _____

Phone: _____ Email: _____

Emergency Contact: _____

Emergency Phone: _____

Registration..... \$95.00

Clinic T-Shirt (Optional)..... \$15.00

T-Shirt Size: (___Youth ___Adult) (___Small ___Medium ___Large ___X-Large ___2XL ___3XL)

**Check One Y or A*

**Check One Size*

Total Enclosed.....\$ _____

Checks Payable To: East Bay Elite Mail To: 31 Parker Ave. Warren, RI 02885

****Spot is not guaranteed until payment is received.**

Medical Release

In consideration of the acceptance of this application for the EAST BAY ELITE/CRYSTL BUSTOS HITTING CLINIC, I am aware of and understand the potential dangers of participating in contact sport activities. I understand that catastrophic injury or accident can occur through participation in softball, and I freely and voluntarily assume all such risks and consent to my child's participation in the clinic.

I, intending to be legally bound hereby for myself, my heirs, executors and administrators, waive and release any and all rights and claims that I may have now or in the future against East Bay Elite, East Bay Fast Pitch Softball, The town of Bristol, RI, Crystl Bustos, Got Bustos and its representatives, employees, respective agents, and/or assignees, for all damages which may be sustained and suffered in connection with my or my child's association with any portion of this clinic or related activities, and which may arise out of my or my child's traveling to or returning from clinic. I know of no medical or physical problems that may affect my child's ability to participate safely in this clinic.

I hereby give my consent to the clinic staff to attend to any health problems or injury my child may incur while attending this clinic. Further, I give my consent for medical treatment and permission to the attending physician to hospitalize, secure proper treatment and order injections, anesthesia, or surgery for my child. I accept full responsibility for the cost of any charges in connection with my child's attendance at this clinic.

Parent/Guardian Signature: _____ Date: _____