



University of Hawai'i Coach Dave Shoji's Volleyball Clinic Application & Waiver Form

FAX Form to 648-2220, or email it to doctorshieh@yahoo.com

Clinic dates will be June 6th, Monday. Times are to be determined, we are having 3 sessions. Please arrive 30 minutes prior to camp time as **e-mailed** for check-in. Enjoy! And Mahalo! For any questions, please contact Ashley Watanabe at quamathletics@gmail.com or doctorshieh@yahoo.com.

NAME:	E-MAIL ADDRESS (FOR FURTHER CLINIC NOTICES):
BIRTHDATE:	SCHOOL:
CELL PHONE: HOME PHONE:	MALE/FEMALE:
FORM OF PAYMENT (CHECK/CASH): FREE - Sponsored by Dr. Shieh's Clinic. Each participant may donate any amount to Guam National Volleyball Federation for the Guam National Women and Men's Volleyball Teams.	MAILING ADDRESS (ATTN TO):

ALL PARTICIPANTS MUST BRING PROTECTIVE KNEE PADS.

The volleyball clinic is free as sponsored by Dr. Shieh's Clinic, however, **donations** can be made to the Guam Volleyball Federation to benefit the Men and Womens' National Volleyball Teams for their off island competition. Thank you for your support!!

PLEASE READ AND SIGN THE MEDICAL CONSENT FORM AND WAIVER AT THE BOTTOM OF THIS FORM:

CONSENT FORM AND WAIVER AGREEMENT:

NAME OF PARTICIPANT _____ DATE OF ACTIVITY _____

I/WE, THE UNDERSIGNED, CERTIFY THAT THE ABOVE NAMED CHILD IS IN GOOD PHYSICAL HEALTH AND IS ABLE TO PARTICIPATE IN ALL ACTIVITIES OF THE ABOVE NAMED PROGRAM. I/WE ALSO UNDERSTAND AND ACKNOWLEDGE THAT THERE ARE INHERENT DANGERS AND RISKS INVOLVED WITH PARTICIPATION IN THE ABOVE NAMED PROGRAM WITH ST. JOHN'S SCHOOL, DR. SHIEH'S CLINIC AND UNIVERSITY OF HAWAII, WHICH INCLUDE, BUT ARE NOT LIMITED TO: DANGERS RANGE FROM MINOR INJURIES, SUCH AS BRUISES, LACERATIONS, STRAINS AND SPRAINS TO SERIOUS CATASTROPHIC INJURIES INCLUDING PERMANENT DISABILITIES AND DEATH, AS WELL AS PROPERTY LOSS AND SEVERE SOCIAL AND ECONOMIC LOSSES. THESE RISKS INCLUDE, BUT ARE NOT LIMITED TO, THOSE CAUSED BY (A) THE ACTIONS, OMISSIONS, OR NEGLIGENCE OF OTHER COACHES, PARTICIPANTS, COMPETITORS, VOLUNTEERS, SPECTATORS; (B) CONDITIONS OF THE PREMISES OR

EQUIPMENT USED; (C) RULES OF PLAY; (D) TEMPERATURE; (E) WEATHER; (F) CONDITIONS OF PARTICIPANTS OR COMPETITORS. I UNDERSTAND THAT I/WE SHOULD BE COVERED DURING THE DATES OF PROGRAM ABOVE BY A PRIVATE MEDICAL AND LIABILITY POLICY/ AND I/WE FURTHER UNDERSTAND THAT ST. JOHN'S SCHOOL/DR. SHIEH'S CLINIC/ AND UNIV. OF HAWAII DOES NOT PROVIDE SUCH INSURANCE OR OTHERWISE INDEMNIFY INDIVIDUALS WITH RESPECT TO INJURIES OR OTHER LIABILITIES ARISING OUT OF PARTICIPATION IN THE ABOVE NAMED PROGRAM. THEREFORE, IN CONSIDERATION OF THE ABOVE NAMED CHILD BEING PERMITTED TO PARTICIPATE IN THE ABOVE NAMED PROGRAM, I/WE HEREBY AGREE TO ASSUME ALL RISKS AND RESPONSIBILITIES SURROUNDING HIS/HER PARTICIPATION IN THE ABOVE NAMED PROGRAM. I/WE HAVE READ AND UNDERSTAND ANY AND ALL WRITTEN MATERIALS SETTING FORTH THE REQUIREMENTS FOR PARTICIPATION IN THE ABOVE REFERENCED ACTIVITY, AS WELL AS THOSE EXPLAINED BY THE INSTRUCTOR(S), AND I/WE AGREE TO STRICTLY OBSERVE THEM. FURTHER I/WE DO FOR MYSELF, MY HEIRS, EXECUTORS, AND ADMINISTRATORS HEREBY ACCEPT FULL RESPONSIBILITY FOR MY CHILD'S PARTICIPATION AND AGREE TO INDEMNIFY, RELEASE AND DISCHARGE ST. JOHN'S SCHOOL/DR. SHIEH'S CLINIC/UNIVERSITY OF HAWAII, TERRITORY OF GUAM/STATE OF HAWAII, ITS OFFICERS, EMPLOYEES, AGENTS, AND ASSIGNS FROM ANY AND ALL CLAIMS OR ACTIONS FOR PROPERTY DAMAGE, PERSONAL INJURY, AND/OR DEATH ARISING FROM SUCH PARTICIPATION IN THE ABOVE NAMED PROGRAM OR GROWING OUT OF OR CAUSED BY ANY ACTS OR OMISSIONS OF THE ABOVE NAMED CHILD DURING THEIR PARTICIPATION IN ABOVE NAMED PROGRAM.

SIGNATURE OF PARENTS/GUARDIAN

DATE

PRINT NAME:

DATE

MEDICAL CONSENT FORM:

I/WE, THE UNDERSIGNED, CONSENT TO AND AUTHORIZE ANY MEDICAL PROFESSIONAL AND OTHERS WORKING UNDER THEIR SUPERVISION TO TREAT THE ABOVE NAMED CHILD FOR ANY INJURY OR ILLNESS ARISING FROM OR RELATED TO MY PARTICIPATION IN THE ABOVE NAMED PROGRAM. I/WE FURTHER AGREE TO PAY ANY AND ALL MEDICAL EXPENSES, COSTS AND OTHER CHARGES AND TO RELEASE AND DISCHARGE AND HOLD HARMLESS ST. JOHN'S SCHOOL/DR. SHIEH'S CLINIC/UNIVERSITY OF HAWAII, TERRITORY OF GUAM/STATE OF HAWAII, ITS OFFICERS, EMPLOYEE'S, AGENTS, AND ASSIGNS FROM AND AGAINST ANY LIABILITY OR ANY CLAIMS OR DEMANDS ARISING FROM OR CONNECTED WITH SUCH MEDICAL TREATMENT OR CARE:

IN CASE OF EMERGENCY:

FIRST PERSON OF CONTACT: _____ PHONE: _____

SECOND PERSON OF CONTACT: _____ PHONE: _____

SIGNATURE OF PARENT/GUARDIANS

DATE

PRINT NAME

DATE

DEADLINE May 30th for registration.

FAX Form to 648-2220, or email it to doctorshieh@yahoo.com or drop them off to Dr. Shieh's Clinic. You will receive an email confirming your registration.

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