

ADULT COED VOLLEYBALL

Starting: Monday, September 9th , 2019

Time: 7:00 – 9:00pm

Where: Sanbornton Central School Gym

Who: Any one 18 years or older

Cost: Resident: \$20.00 / Non- Resident: \$30.00

Any questions please contact the Sanbornton Recreation
603- 286-2659 or 603-393-6665 or email: sanbrec@metrocast.net

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2019-2020 - Sanbornton Recreation – Coed Volleyball Program

Name: _____ Date: _____

Address: _____

Phone: _____ Cell: _____

E-Mail Address: _____

I, _____ assume all risks and hazards incidental to such participation including transportation to and from the activities, and I do hereby waive, release, absolve, indemnify and agree to hold harmless the Sanbornton Adult Co-Ed Volleyball Program, the organizers, sponsors, supervisors, and participants from any claim arising out of any injury to myself.

As a participant in Adult Co-Ed Volleyball, I will be responsible for leaving the area used in the same condition as upon my arrival. In case of accident, I request the Sanbornton Adult Co-Ed Volleyball Program to contact:

Name: _____ Phone #: _____


If unavailable, please contact the physician indicated below and follows his/her instructions. I authorize any treatment deemed necessary for myself.

Physician: _____ # _____

Player Signature: _____ Date: _____

For office personnel, only: Name: _____ Date: _____ 2019 / 2020 Resident: \$20.00 Non-Resident \$30.00 <input type="checkbox"/> Cash Payment \$ _____ <input type="checkbox"/> Receipt # _____ <input type="checkbox"/> Check Payment: \$ _____ Check #: _____
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2019-2020 - Sanbornton Recreation – Pickle Ball Program

Name: _____ Date: _____

Address: _____

Phone: _____ Cell: _____

E-Mail Address: _____

I, _____ assume all risks and hazards incidental to such participation including transportation to and from the activities, and I do hereby waive, release, absolve, indemnify and agree to hold harmless the Sanbornton Adult Co-Ed Volleyball Program, the organizers, sponsors, supervisors, and participants from any claim arising out of any injury to myself.

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Name: _____ Phone #: _____

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Physician: _____ # _____

Player Signature: _____ Date: _____

For office personnel, only: Name: _____ Date: _____ 2019 / 2020

Resident: \$20.00 Non-Resident \$30.00

Cash Payment \$ _____ Check Payment: \$ _____ Check #: _____

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