



**Clinic Registration Form**  
**Wallace State Community College**

**Please Print**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number(s) Home \_\_\_\_\_ Cell \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

School \_\_\_\_\_

I, \_\_\_\_\_ have completed the above information and declare it to be true and accurate. Further, I understand that my participation in this clinic held on the campus of Wallace State Community College is at my own risk. I hereby release Wallace State Community College Administration / preventatives, Wallace State Community College Athletic Department, Wallace State Community College, and the coach (es) for any liability, for any injury, accidents or illness which may occur as a result of my participation in the clinic.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Coach's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_