

Please print and Mail with Check:  
(make check payable to Ohlone College Softball)

**OHLONE SOFTBALL CAMP  
OHLONE COLLEGE ATHLETIC DEPARTMENT  
43600 MISSION BLVD., FREMONT, CA 94539**

*Registration Form*

Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Day phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Group Name (if any) \_\_\_\_\_

Parent's Name(s) \_\_\_\_\_

**(Hours for camp are 9am to 2pm)**

**One Week Only: July 28-August 1, 2008**

**Cost: \$125.00**

INSURANCE WAIVER & EXPLANATION

(Guardian's Name)

FOR MYSELF, MY HEIRS, EXECUTORS, ADMINISTRATORS, AND ASSIGNS, I \_\_\_\_\_  
HEREBY RELEASE THE OHLONE COMMUNITY COLLEGE DISTRICT AND THE STATE OF CALIFORNIA FROM ANY  
AND ALL CLAIMS, DEMANDS, OR LIABILITY OF ANY KIND, FROM WHATEVER CAUSE, WITHOUT LIMITATIONS,  
WHICH MAY ARISE FROM DAMAGE, INJURY, ILLNESS, DEATH, OR ACCIDENT OCCURRING TO MY SON OR  
DAUGHTER.

\_\_\_\_\_  
(Name of Participant)

DURING HIS/HER PARTICIPATION IN THE OHLONE COLLEGE SOFTBALL CAMP ON JULY 28-AUGUST 1, 2008. I  
AGREE NOT TO SUE OR PROSECUTE ANY CLAIM DEMAND, OR SUIT HAVE ANY KIND, DIRECTLY OR INDIRECTLY,  
IN RESPECT THERETO. I FURTHER CERTIFY THAT I HAVE ACCIDENT AND HEALTH INSURANCE COVERAGE  
WITH:

\_\_\_\_\_  
(Name of Insurance Company)

\_\_\_\_\_  
(Policy Number)

I HAVE READ EVERY WORD OF THIS RELEASE

\_\_\_\_\_  
SIGNED

\_\_\_\_\_  
DATED

If you have any questions, please contact (510) 659-6053

Sincerely,  
Donna Runyon  
Ohlone College Softball Coach