



## **BASKETBALL CLINIC**

Coach Childress will be conducting basketball clinics for Riverside students. The first set of clinics are:

**North Building:**

February 12 from 2:15-3:30

February 19 from 2:15-3:30

February 26 from 2:15-3:30

The first 8 students to return their basketball release form on the back of this information sheet, along with the \$35 activity fee, will reserve their spot. If paying by check, please make checks payable to Riverside School. As in the past, our focus is centered on learning teamwork and basketball skills, encouraging full participation, and having FUN! The clinic will be held outside, weather permitting. In the event of inclement weather, activities will move indoors to St. Michael's gym. Masks will be worn when social distancing can not be maintained.

Participants will need to bring the following items:

- Change of clothes
- Water bottle
- Basketball - if your child wants to bring their own

Pickup after practice will be in the front of Riverside School. Use the McRae Road entrance for basketball pick up. Any questions? Please contact Coach Childress at [cchildress@riversideschool.org](mailto:cchildress@riversideschool.org)

*See back for Release Form*

# BASKETBALL RELEASE FORM

## WINTER 2021

I understand there are certain risks inherent in the participation of sports, and I am willing to assume these risks. In addition to giving full consent for my child's participation, I do hereby waive, release and hold harmless Riverside School, its officers, coaches, and employees for an injury that may be suffered by my child in the normal course of the participation of the soccer activities incidental thereto, whether the results of negligence or any other cause.

Signature of  
Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby give my permission for any and all medical attention necessary to be administered to my child,

\_\_\_\_\_  
Child's Name Date of Birth

In the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted, this release is effective for a period of one year from the date given below. I also assume the responsibility for the payment of any such treatment, including, but not limited to transportation for required treatment.

Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group # \_\_\_\_\_

In case I cannot be reached, I give permission to the Coach, Team Parent, or School Designee, to act on my behalf.

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital: \_\_\_\_\_

Known Allergies: \_\_\_\_\_

Other Important Medical Information:

Signature of  
Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_