RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND PARENT CONSENT FORM

I/We hereby understand and acknowledge that the participating and/or observing the training, programs, and events held by the SUNRISE COURTS/PUYALLUP JUNIORS VOLLEYBALL CLUB may expose me to many inherent risks, including accidents, injury, illness, or even death. I/We assume all risk of injuries associated with participation including, but not limited to, falls, contact with other participants, the effects of the weather, including high heat or humidity, and all other such risks being known and appreciated by me. I/We hereby acknowledge SUNRISE COURTS/PUYALLUP JUNIORS VOLLEYBALL CLUB is not responsible for the possible contraction of airborne illness (including but not limited to influenza, common cold, COVID-19, etc. I/We hereby acknowledge my responsibility in communicating any physical and psychological concerns that might conflict with participation in activity. I/We acknowledge that I am physically fit and mentally capable of performing the physical activity I choose to participate in.

After having read this waiver and knowing these facts, and in consideration of acceptance of my participation and the SUNRISE COURTS/PUYALLUP JUNIORS VOLLEYBALL CLUB furnishing services to me, I agree, for myself and anyone entitled to act on my behalf, to HOLD HARMLESS, WAIVE AND RELEASE the SUNRISE COURTS/PUYALLUPJUNIORS VOLLEYBALL CLUB, its officers, agents, employees, organizers, representatives, and successors from any responsibility, liabilities, demands, or claims of any kind rising out of my participation and/or observation in the SUNRISE COURTS/PUYALLUPJUNIORS VOLLEYBALL CLUB training, programs, and/or events.

By my signature I/we indicate that I/we have read and understand this waiver of liability. I am aware that this is a waiver and release of liability and I voluntarily agree to its terms.

PARTICIPANT Name (Please Print)_____

Participants Date of Birth (If under 18 years of Age)_____

ARE YOU CURRENTLY EXPERIENCING ANY COVID SYMPTOMS?
Cough, Shortness of breath or difficulty breathing, Fever, Chills, Muscle pain, Sore throat, New loss of taste or smell

Yes_____No_____

PARENT/GUARDIAN Name (Please Print)_____

Email Address_____Phone_____

Participant Signature_____Date_____

Parent Signature (If under 18 years of Age)_____Date_____