

DISTRICT ATTORNEY SAM SUTTER'S

Free One Day Baseball Clinic for Fall River Youth

All Registration Forms **MUST** be **MAILED, FAXED** or **RETURNED** to the following location:

District Attorney's Office
Attn: Brian Rose
888 Purchase St, New Bedford MA 02740
508-991-7641 Fax

Child's Name: _____ Age: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Address: _____ City: _____ State: _____ Zip Code: _____ Telephone #: () _____ - _____	Emergency Contact Info: Parent/Guardian: _____ Cell Phone: () _____ - _____ Alt Phone #: () _____ - _____ Email: _____
---	---

Media Release

I give permission for photographs, audio tape recordings and video recordings taken of my son/daughter _____ at the Free Sports Clinics sponsored by the Bristol County District Attorney's Office, can be used by the Bristol County District Attorney for publicity purposes.

X _____
Signature of Parent or Guardian

Date

SPACE IS LIMITED!!!

Please note: Transportation to and from the clinics is not provided.
All parents and children are responsible for securing their own transportation to and from the clinics.

***Please check time below:

Saturday, April 10, 2010

****One Day Only****

1pm - 4pm

Durfee High School - 360 Elsbree Street, Fall River

****Inside if Raining****

- Grades 1-4 will meet from 1pm - 2:30pm.
- Grades 5-8 will meet from 2:30pm -4pm.

Important!

Please read the following carefully and sign below.

In consideration of recreational baseball services provided by the Massachusetts District Attorney for the Bristol District, C. Samuel Sutter, individually and/or in his official capacity, his employees or volunteers (hereinafter "provider"), I agree to hold harmless, release and/or discharge said provider from any and all injury past, present or future, any past, present or future claim, or potential claim as a result of any negligent act, willful or wanton negligent act or intentional act by any third party known or unknown, foreseen or unforeseen, anticipated or unanticipated. I further agree to indemnify said provider for any and all loss incurred by said provider as a result of any and all claims made as a result of my participation in the services made available by the provider.

Parent/Guardian Signature: _____

I have read and understood all of the information presented above.

Parent/Guardian Name: _____
(Please print.)

Signature: _____

Date: ____/____/____

For more information, please contact:
Brian Rose, DA Volunteer Coordinator at (508) 961-1972.

