



# AVALANCHE VOLLEYBALL CLUB, LLC SKILLS CLINIC

: Setting : Passing : Serving : Hitting :

**Who:** Any athlete, 4<sup>th</sup>- 8<sup>th</sup> grade, that is interested in learning volleyball skills!!

**When:** SATURDAY, February 1st, 2020  
9:00am-12:00pm

**Where:** Elder Grove School School

**Cost:** \$25.00

**Clinician:** Natalie Bills, director of Avalanche Volleyball Club, and former setter at Montana State University-Billings.

**\*Each participant will need to show proof of AAU membership.** Register at [aausports.org](http://aausports.org) \*Prior to the clinic please complete and mail registration form and payment to Natalie Bills at 3274 Granger Ave. #I-3 Billings, MT 59102. Check-in will begin 45 minutes prior to the start of the clinic. \*For more information please call Natalie Bills at 801-885-3916, email [avalanche.vbc@gmail.com](mailto:avalanche.vbc@gmail.com) or visit [avalanchevbc.com](http://avalanchevbc.com)

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## VOLLEYBALL CLINIC REGISTRATION FORM- 2020

Player Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

### Waiver and Release of Liability Form-Avalanche Volleyball Club, LLC

I \_\_\_\_\_, will be a participant at the Avalanche VBC Skills Clinic. I hereby waive all claims for injury or accident of any kind against Trinity Lutheran Schools, Billings Public Schools, Elder Grove School, Avalanche Volleyball Club, LLC, or any of the coaches, all employees, sponsors, or members of the team participating in these sessions. I am aware that the athlete is covered by their own family insurance. I am also aware that the athlete is in good physical shape. If the athlete does have an underlying medical problem or recent injuries, I will check in with the coaches and notify them of my circumstances prior to any participation. In the event that she is injured while under the care of Avalanche Volleyball Club, LLC and its representatives and requires the attention of a doctor, I hereby consent to and will be responsible for any reasonable medical treatment as deemed necessary by a licensed physician. All participants under the age of 18 years old must have a guardian's signature.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_