2021 Rox Youth Clinics

Do you want to do something that Rox? The St. Cloud Rox are offering a Fundamental Baseball

Clinic in ______________________ on ______________________ at ______________________.

CITY **DATE** **LOCATION**

The two-hour clinic **(10 a.m. to noon)** is open to all boys and girls, ages 7-14. The clinic provides instruction from your favorite Rox players and coaches. Along with learning the fundamentals of baseball each participant will receive a free ticket voucher to a 2021 Rox game, extensive baseball instruction, a unique Rox poster for autographs following the clinic, and most of all, ROX SOLID FUN!

Rox players and coaches will provide one-on-one baseball instruction. Participants will gain experiences and knowledge from some of tomorrow's baseball stars.

The Rox are dedicated to providing fundamental baseball skills to children in the area. Learn how to play the game the right way!

The Rox Youth Clinic is only $15 per person. (Includes game ticket and poster.)

Clinic Participant's Name: ____

Age: ________

Male: ________ Female: ________

Address: ____

City: ___________________ State: _________________ Zip Code: ________________

Phone Number: _________________________ Email: __________________________

For more information, contact Jeff at: jeff@stcloudrox.com

ROX INSTRUCTIONAL CLINIC PARENTAL AUTHORIZATION

WE (OR I) AUTHORIZE THE ROX INSTRUCTIONAL CLINIC, OR IT'S DESIGNEE, TO SELECT HOSPITAL FACILITIES AND/OR A PHYSICIAN OF HIS CHOICE AND AUTHORIZE TREATMENT OF THE BELOW NAMED APPLICANT ON A NY EMERGENCY BASIS IN THE EVENT SUCH TREATMENT BECOMES NECESSARY. WE (OR I) WILL BE RESPONSIBLE FOR ALL BILLS INCURRED AS A RESULT OF ILLNESS OR ACCIDENT WHILE THE BELOW NAMED APPLICANT IS AT THE ROX INSTRUCTIONAL CLINIC, EXCEPT BILLS COVERED BY INSURANCE. WE (OR I) HEREBY REQUEST YOU ACCEPT THE APPLICATION FOR ENROLLMENT OF THE BELOW NAMED APPLICANT FOR THE ROX INSTRUCTIONAL CLINIC. IN CONSIDERATION OF YOUR ACCEPTANCE OF THE APPLICATION, WE (OR I) HEREBY RELEASE THE ST. CLOUD ROX, SCOTT SCHREINER, MICHAEL JOHNSON, OR ANY OTHER CLINIC EMPLOYEES FROM ALL CLAIMS ON ACCOUNT OF ILLNESS, INJURIES, OR DISEASES WHICH MAY BE SUSTAINED BY THE BELOW NAMED APPLICANT WHILE ATTENDING THE ROX INSTRUCTIONAL CLINIC, AND WE (OR I) FURTHER AGREE TO INDEMNIFY THE ST. CLOUD ROX AND ITS COACHES FOR ANY CLAIM WHICH MAY HEREAFTER BE PRESENTED BY THE APPLICANT

DATE: ____________________________

APPLICANT'S NAME (PRINTED): ____

PARENT/GUARDIAN NAME (PRINTED): _________________________________

PARENT/GUARDIAN NAME SIGNATURE: ________________________________

EMERGENCY CONTACT

PHONE NUMBER: _______________________________________

EMAIL ADDRESS: _______________________________________

Please fill out both forms and return to the St. Cloud Rox one week prior to clinic date.

St. Cloud Rox Baseball Club
Attn: Youth Clinic
PO Box 7216
St. Cloud, MN 56302
(Please make check payable to St. Cloud Rox)

ROX