

**VOLUSIA COUNTY SENIOR SOFTBALL
DAYTONA BEACH LEISURE SERVICES
WAIVER, RELEASE AND HOLD HARMLESS FORM**

The undersigned player or participant (THE RELEASOR) voluntarily agrees to the following provisions, as consideration for the above Associations' supervision and operation of softball events.

This FORM and Agreement waives, releases and discharges any and all agents, servants and employees of Volusia County Senior Softball (VCSS), Daytona Beach Leisure Services, including but not limited to their officers, directors, team managers, umpires, sponsors, supervisors, other players and any other participants, herein known as the RELEASEES.

1. Playing or participating in these events, is a test of the player's or participant's physical and mental limits which has potential for serious injury, death or property damage.
2. Playing or participating in these events, may expose me to dangerous conditions including the use of high-velocity, composite bats, airborne softballs and players running.
3. This FORM is also binding upon any person or entity who succeeds to my rights or responsibilities, including but not limited to my executors, heirs, assigns, next-of-kin and successors-in-interest.
4. I hereby waive release and discharge from any and all claims or liabilities for personal injuries, damages, death or other losses, for negligent acts or omissions, related to or arising from my participation or presence in or at any such athletic events. Such waiver, release and discharge includes: traveling to or from such events or related events; tryouts; drafting events; meetings; participation at any such events or related activities and my presence at any such events or related activities.
5. I also agree not to file any such legal action against any of the above-named entities, agents, servants or employees.
6. I also HOLD HARMLESS all the entities, agents, servants and employees referred to above and agree to INDEMNIFY them against any claims of third parties, resulting from any said injuries or damages, including any claims or bills from my medical providers or my insurance companies.

BY SIGNING THIS FORM, I AFFIRM THAT I AM OTHERWISE ELIGIBLE, I HAVE READ THIS DOCUMENT, AND UNDERSTAND ITS CONTENTS.

NAME: _____

SIGNATURE: _____

ADDRESS STREET/CITY/ZIP: _____

EMAIL: _____

CELL: _____ **DATE OF BIRTH:** _____

EMERGENCY CONTACT NAME: _____ **PHONE:** _____

DATE: _____