

TOURNAMENT TUNE UP CAMPS

11:00 am-12:00pm

- June 11th, 12th session 1
- June 18th, 19th session 1
- June 25th, 26th session 1
- July 9th, 10th session 1
- July 16th, 17th session 1

12:00pm-1:00pm

- June 11th, 12th session 2
- June 18th, 19th session 2
- June 25th, 26th session 2
- July 9th, 10th session 2
- July 16th, 17th session 2



WHERE: Players Only Inc. 9805 Hamilton Road, Eden Prairie, MN 55344

COST: \$60

Staff: TBD from Tom Nevers Baseball Staff
6:1 player to coach ratio



Name: _____ **age:** _____

Address: _____

Phone number(s): home _____ cell _____

E-mail address: _____

Emergency contact: _____ **phone:** _____

For more information about Tom Nevers Clinics, camps, and lessons...

Website: www.playersonlyinc.com E-mail: lessons@tomneversbaseball.com or call 952-224-1200 ext. 12

Please make checks payable to **Tom Nevers Baseball** and send with registration form to the following Address:

Tom Nevers Baseball
6033 Kaymar Drive
Edina, MN 55436

Parents, please read and sign: PLAYERS ONLY INC, TOM NEVERS BASEBALL CLINCS and TRAINING DISCLAIMER OF RESOPNSIBILITY FOR PERSONAL INJURY.

I understand that if my child is injured during any Tom Nevers Baseball Clinics or Training Sessions at Players Only Inc related activity and should require medical attention, appropriate medical care will be summoned and/or an ambulance will be called. If I am not available, I understand that every effort will be made to contact me, and to avoid delay in treatment: I consent to costs related to treatment: (beyond those covered by insurance). I give my authorization for my child to participate in the Tom Nevers Baseball Clinics and Training program, and hear by release, indemnify, and hold harmless Tom Nevers, the Tom Nevers baseball clinics and Training, its staff, and agents from any claim or liability for accident or injury that occurs while participating. This is an activity that injuries may occur and could be serious in nature. I, the parent or legal guardians of the above registrant, acknowledges and understands that they are solely responsible for any medical expenses that may occur.

Signature: _____ Date: _____