



## Softball

# 2009 Husky Softball November Pitching/Catching Clinic

**Date: Saturday, November 15, 2009**  
**Pitching Session: 10:00-12:00**  
**Catching Session: 10:00-12:00**  
**Location: St. Cloud State University**  
**Halenbeck Hall Fieldhouse**  
**Open to: Ages 10-18**  
**Cost: \$ 35.00 Pitching Session**  
**\$25.00 Catching Session**

**\*\*No Refund wills will Be issued Once Registered**  
**\*\*Limited Enrollment in both sessions.**  
**Selection based on date of applications received in date**  
**\*\*Pitchers should bring a catcher to work with them.**

**What to Bring; Glove, water bottle, Indoor Shoes**

*Pitchers-Skill Development and review of pitching techniques. Drill packet to take home in the "off-season" and instruction from the Husky Pitchers and Coaching Staff.*

*Catchers-Defensive Skill Session. Blocking Technique, Footwork and Throwing Drills, Signal Calling, Working with the Pitching Staff, working with the Defense on relays, cuts, and blocking the plate.*

## To enroll, just complete the following form:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Contact Number:: \_\_\_\_\_

Age: \_\_\_\_\_ Grade in School: \_\_\_\_\_ School Attending: \_\_\_\_\_

Position (s) \_\_\_\_\_ Email Address: \_\_\_\_\_

Yes, I will be attending the pitching session and have enclosed my check for \$35: \_\_\_\_\_

Yes, I will be attending the catching session and have enclosed my check for \$25: \_\_\_\_\_

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\*\*\*Please contact Coach U'Ren with any questions at 320-308-2900 or [pjuren@stcloudstate.edu](mailto:pjuren@stcloudstate.edu)  
Go Huskies!







## Softball

Please make checks payable to: **SCSU Softball**

Send payments to: 720 4<sup>th</sup> Ave S.  
Halenbeck Hall 322-St. Cloud State Softball  
St. Cloud University  
St. Cloud, MN 56301

### Waiver Must be Signed Before Participation:

Please note any medical conditions that St. Cloud State University should be aware of:

Known Medical Allergies: \_\_\_\_\_ Current Medication: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I hereby authorize the SCSU clinic director to act for me according to his/her best judgment in any emergency requiring medical attention. I hereby waive and release SCSU from any and/or all liability for any injuries or illnesses incurred while at the clinic or in transportation to a medical facility, except for injury directly resulting from gross negligence or willful misconduct. I have no knowledge of any physical impairment that would be affected by the above name clinical participation in the clinic, as outlined by the brochure.

Parent of Guardian Signature: \_\_\_\_\_

Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_