



## Softball

# Husky Softball October Fundamental/Pitching Skills Clinics

**Date: Sunday, October 12, 2008**  
**Pitching Clinic: 10:00-12:00pm**  
**Fundamental Clinic: 1:00-3:30pm**

**Location: St. Cloud State Softball Field**  
**Selke Field (Located off University and 12th Avenue SE)**

**Open to: Ages 10-18**

**Cost: \$30 For Each Session or \$55 for Both**

**What to Bring; Glove, water bottle, Outdoor shoes, tennis shoes (For Indoor Site), helmet, and bat**

**\*\*Pitching Clinic will cover topics such as proper warm up, pre-practice/pre-game routines, pitching fundamental skills, pitching mechanics, and speed training for pitchers.**

**\*\*Fundamental Clinic will cover topics such as hitting techniques and mechanics, fielding and throwing skills and mechanics, and player development techniques.**

### 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 would like to enroll in the Pitching Skills Clinics: \_\_\_\_\_

Yes, I would like to enroll in the Fundamental Skills Clinic: \_\_\_\_\_



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Please make checks payable to: **St. Cloud State 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

\*\*\*\*\*You will receive confirmation of enrollment via email.

\*\*\*\*\*Enrollment is limited.

### 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: \_\_\_\_\_