

# St. Cloud State University Softball



## Fundamentals Clinic

### Instruction from SCSU Coaches and Players

**What Sessions Include:** This clinic is a continuous, progressive clinic. Each day will introduce new material. Pick and choose the sessions that work for you. Areas covered will include:

- ❖ Proper Defensive Fundamentals
- ❖ Offensive Techniques
- ❖ Team play
- ❖ Skill Development

**When:** Jan 21<sup>st</sup> and 28<sup>th</sup>

**Time:** 10:30 am-12 pm

**Where:** The Husky Dome

**Cost:** \$20 per session

**What to Bring:** Players should be dressed to participate. They should bring a glove, batting gloves, sweatpants, a water bottle, and wear tennis shoes.

**For questions or to reserve a spot please feel free to contact  
Head Coach Paula U'Ren at  
pjuren@stcloudstate.edu or 320-308-2900**



# St. Cloud State University 2007 Softball Clinic Registration Form

Please Print

Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Graduation Year \_\_\_\_\_

School \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**Primary Position** \_\_\_\_\_

Skill Level (circle one) Beginner Intermediate Advanced

**Secondary Position** \_\_\_\_\_

Skill Level (circle one) Beginner Intermediate Advanced

**Session 10:30am- 12pm**

**Date Attending (Please Circle)-Mark information on your Calendar**

January 21

January 28

**Cost:** \$20 per session

- Please make checks payable to Head Coach Paula U'Ren
- Send payments to: 720 4<sup>th</sup> Ave S.  
Halenbeck Hall 322 – St. Cloud State Softball  
St. Cloud University  
St. Cloud, MN 56301

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

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 or Guardian Signature: \_\_\_\_\_

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