NORWALK PARKS & RECREATION
100 Republic St., (419) 663-6775
www.norwalkrec.com

YOUTH VOLLEYBALL CLINICS– SUMMER 2026

Join coach Konik and her passion for volleyball and creating a positive environment where players can grow their skills in confidence. These clinics will focus on developing and improving fundamental skills through repetition in a variety of drills and games.

Ages: 4-8 grade (2026-27 school year)
Dates: July 7-9
Time: 4:30-6:00pm (4-6 grade)
6:15-7:45pm (7-8 grade)

Cost: $40
Registration: June 8-28

Anyone wishing to participate must return this contract with the player's fee to the Ernsthausen Recreation Center by June 28th. Checks are to be made payable to 'City of Norwalk'.
(The Park & Rec. Dept. does offer financial assistance for youth fees. Please contact the center for information).

Child's Name_____ School_____Member Exp._____
Address_____ City_____ Phone_____
Grade_____ (2026-27 school year) Birthdate____/____/____ Male____ Female____ Height___'___" Weight_____

Parent email _____

Mother's Name_____ Home Phone_____
Mother's Employment_____Business Phone_____
Father's Name_____Home Phone_____
Father's Employment _____Business Phone _____
Alternate person to be contacted_____ Phone_____

Facts concerning your child's medical history including allergies, medications being taken, and any physical impairments that would be beneficial for this department to be aware of:
_____

I agree that I will hold harmless and indemnify any rights and claims for damages against the Norwalk Parks & Recreation Dept. or the City of Norwalk for any injuries incurred during activities my child is participating in, including but not limited to exposure to or illness resulting from COVID-19. I assume all responsibility as a result of my child being permitted to participate in the programs. The alternates listed above are hereby authorized in my absence to consent for treatment to be given to my child. In the absence of myself and all alternates listed above, I hereby give my consent for treatment deemed necessary by any acting physician or dentist.

Signature of Parent or Guardian_____ Date_____

RN:_____ Date_____ Amt. Pd._____ ☐ Initials_____ ☐ **SCA form**