2015 DISTRICT VOLLEYBALL REGISTRATION
TEAM VOLLEYBALL

Please Print Clearly:

Agency Number: _____ Agency Name: _____

**Head Coach: _____ W: (_____) _____ H: (_____) _____

Address: _____
(City) (State) (Zip)

Fax: (_____) _____ E-mail: _____

Cell phone contact number while at the Tournament: (_____) _____

I have verified that all chaperones attending the tournament are approved SOWI Class A certified volunteers ☐ (check √).

RETURN THIS FORM TO THE HOST REGIONAL OFFICE BY THE PUBLISHED DEADLINE DATE!

Team Name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Each team must have a unique name up to **15 characters long**.

CHECK ALL ITEMS:

☐ New Team ☐ Existing Team

	ATHLETE NAMES (ALPHABETICAL: LAST NAME, FIRST)	*VSAT SCORE	TOP 6 [X}
1.			☐
2.			☐
3.			☐
4.			☐
5.			☐
6.			☐
7.			☐
8.			☐
9.			☐
10.			☐
11.			☐
12.			☐
	COMPUTE THE AVERAGE OF TOP SIX VSAT SCORES =		

*See volleyball rules for skills calculation.

**Registration information will be sent to person listed as head coach.

By submitting this form I verify that the athletes on this roster competed in at least two of the documented qualifying matches ☐ (check √).

(OVER)

2015 VOLLEYBALL SEASON

Please Print Clearly:

Agency Number: _____ Agency Name: _____

Team Name: _____

Total Agency number of coaches and chaperones that will be attending this district tournament: _____

Reminder: *athlete to coaches/chaperone ratio is minimum of 4:1*

LIST ALL VOLLEYBALL MATCHES PLAYED THIS SEASON

(A minimum of **TWO MATCHES** must be documented here **before** the registration deadline date. **ONE** match must be played against a team from another Special Olympics Agency.)

AGENCY NUMBER	OPPOSING TEAM OFFICIAL NAME	DATE OF MATCH	YOUR SCORE	THEIR SCORE
			1) _____ 2) _____ 3) _____	1) _____ 2) _____ 3) _____
Comments:				
			1) _____ 2) _____ 3) _____	1) _____ 2) _____ 3) _____
Comments:				
			1) _____ 2) _____ 3) _____	1) _____ 2) _____ 3) _____
Comments:				