



SOFTBALL ONTARIO'S TRY SOFTBALL REQUEST FORM

Fax: (416) 426-7368

School Name: _____

Contact Name: _____

Address: _____

City: _____ Postal Code: _____

Phone Number: () _____ Fax: () _____

Email: _____

Please indicate during which months you are able to participate in the BlastBall program:
(Mark your 1st, 2nd and 3rd choice)

- | | | |
|---|---|--|
| <input type="checkbox"/> September ____choice | <input type="checkbox"/> October ____choice | <input type="checkbox"/> November ____choice |
| <input type="checkbox"/> December ____choice | <input type="checkbox"/> January ____choice | <input type="checkbox"/> February ____choice |
| <input type="checkbox"/> March ____choice | <input type="checkbox"/> April ____choice | <input type="checkbox"/> May ____choice |
| | <input type="checkbox"/> June ____choice | |

If you have a specific date in mind when you would like to use the Kit, please let us know. If you cannot utilize the Kit during one of the above months but would like to be considered in a future mailing, please indicate below.

We will send you an email confirming your final usage period.

PARTICIPANT INFORMATION

Number of Children participating: Age 4 – 6 ____ Age 7-8 ____ Age 9-12 ____

Number of Classes participating: JK - Grade 2 ____ Grade 3-4 ____ Grade 5-6 ____

TERMS/CONDITIONS

- ◆ Schools that receive a BlastBall Kit are expected to return the kit to the Softball Ontario office at the **school's expense** on the date discussed in the letter enclosed in the Kit.
- ◆ There is no charge for the loan of the kit if all kit components are returned on time and undamaged.

I agree with the Terms/Conditions as stated above.

Print Name _____



_____ Date



Signature _____