Pop Warner Little Scholars, Inc.

EASTERN REGION

Capital District

2025 WAIVER FORM

Date_____

Participant Name:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Date of Birth:_____

Releasing Association:_____ **Receiving Association:**_____

I _____ President of _____

(President Releasing Signature) *(Print Releasing* Association*)*

Hereby waive the name Participant above who resides inside the boundaries of the releasing association to participate in the receiving association for the _____ Season.
(Print Year)

This wavier terminates at the end of the current season for receiving association.

We understand and agree that a waiver will be required for this individual each and every year as long as his/her home organization has a team in which he or she can participate.

Signature of receiving Association _____ President of _____

(President Signature) *(Print Receiving* Association

___ Level of Play not available in Releasing Association Level of play_____

___ Closest Level of Play is in Receiving Association Level of play_____

___ Sibling Playing on a Level not Available in Releasing Association

___ In care of a Parent or Guardian of Receiving Association

___ Other_____

Signature of Capital District Board Member _____