

2010 Fall Ball Registration

LEAGUE USE ONLY:
Paid: _____ Team: _____

Player: _____ Date of Birth: _____
Last Name First Name MM/DD/YYYY

Address: _____

Home Phone: _____ School & Grade: _____

Father: _____ Email: _____
Last Name First Name

Work Phone: _____ Mobile Phone: _____

Mother: _____ Email: _____
Last Name First Name

Work Phone: _____ Mobile Phone: _____

2010 Spring Baseball League: _____ Division: _____ Team: _____

I, the parent or legal guardian of the named player on this application as a candidate for a position on a Fall Ball Little League team, hereby give my permission to participate in any and all Fall Ball Little League activities. I clearly understand that participation in baseball may result in serious injuries and protective equipment cannot prevent all injuries to players. I assume all risks, responsibilities and hazards incidental to such participation including transportation to and from the activities. I do hereby waive, release, absolve, indemnify and agree to hold harmless the Little League organizations involved, including but not limited to Tri-Cities Little League and Little League Baseball Inc., the organizers, sponsors, coaches, supervisors, participants and persons transporting my child to and from activities, for any claim arising out of an injury to the player, whether the result of negligence or for any other cause except to the extent and in the amount covered by the accident or liability insurance. I further understand that in case of injury to the player, my own personal medical plan will be used prior to the insurance provided through Little League Baseball Inc. My signature on this form authorizes permission and medical release, and signifies that the answers on this application are true and correct.

Medical Release and Parent/Guardian Authorization

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel. (i.e., EMT, First Responder, E.R. Physician).

Physician Name: _____ Phone: _____

Dentist Name: _____ Phone: _____

Insurance Carrier: _____ ID#: _____

Hospital Preference: _____

In case of emergency contact:

Name Phone Relationship to Player

Name Phone Relationship to Player

Please list any allergies, medical conditions, allergic drug reactions and other important medical information:

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Parent/Guardian Signature: _____
Signature Print Name Date