

## **T-Ball/Lob Ball Registration Form**

Please Circle one:     \$35.00-T-Ball 4-6yr olds     \$35.00-Lob Ball 7-8yr olds

To play in T-Ball players must be 4, 5, or 6 by May 24<sup>th</sup>

To play in Lob Ball players must be 7 or 8 by May 24<sup>th</sup>

### General Information

Player Name \_\_\_\_\_ Gender \_\_\_\_\_

Parents Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Township \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Email \_\_\_\_\_

Shirt Size:    YS    YM    YL    AS    AM    AL    AXL

### Past Information

What League did your child play in last year? Please circle one: T-ball    Lob Ball    None

### Coaching

Would you like to volunteer as a head coach?    YES    or    NO

Would you like to volunteer as an assist coach?    YES    or    NO

If so, please fill out a criminal history background check questionnaire.

**Would you or someone you know be interested in sponsoring a team? YES    or    NO**

Sponsorship of a T-Ball or Lob Ball Team - \$150.00

Business Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone \_\_\_\_\_

Where/how could we get your logo for the uniforms? \_\_\_\_\_

What are your top three color choices would you like the uniforms?

1.) \_\_\_\_\_

2.) \_\_\_\_\_

3.) \_\_\_\_\_

**For Sponsorship** please check how you would like to pay:

\_\_\_\_ Pay now            \_\_\_\_ Invoice me

Name of Parent or Guardian (please print) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Medical Release Form**

Player Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Insurance Information**

Policy Number \_\_\_\_\_ Name of Health Insurance Provider \_\_\_\_\_

Family Physician \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Hospital Preference \_\_\_\_\_

**In case of emergency contact:**

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Name	Phone	Relationship to Player
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Name	Phone	Relationship to Player
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Please list any allergies/medical problems, including requiring maintenance medication (i.e. Diabetic, Asthma, Seizures).

Medical Diagnosis	Medication	Dosage	Frequency of Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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.

Date of last Booster Shot: \_\_\_\_\_

**Parent or Guardian Authorization**

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

Mr./Mrs./Ms.

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Authorized Parent/Guardian Signature

\*\*\* Warning: Protective equipment can't prevent all injuries a player might receive while participating in the program.