



Baseball/Softball Player Registration

Lower Swatara Township Athletic Association

Player Information

Player Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Gender: Male Female

Mobile Phone: _____

Shirt size: _____ Pants size: _____

Email: _____

Date of Birth: _____ *Player Age: _____ *(Age as of - Baseball: 08.30.19 / Softball: 12.31.18)

School Grade: _____ School: _____ Uniform # preference: _____

Parent Information

Parent/Guardian Name: _____

Parent/Guardian Name: _____

Phone: _____

Phone: _____

Alternate Phone (cell/work): _____

Alternate Phone (cell/work): _____

Email Address: _____

Email Address: _____

Emergency Contact Information

| Name | Phone | Relationship to Player |
|-------|-------|------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

I/We, the parents/guardians of the above-named candidate for a position on a youth baseball team within the Lower Swatara Township Athletic Association (LSTAA), hereby give my/our approval to participate in any and all baseball activities, including transportation to and from the activities. I/We know that participation in baseball or softball may result in serious injuries and protective equipment does not prevent all injuries to players, and do hereby waive, release, absolve, indemnify, and agree to hold harmless the Lower Swatara Township Athletic Association, its Board of Directors, its members, the organizers, sponsors, supervisors, participants, and persons transporting my/our child to and from activities from any claim arising out of any injury to my/our child whether the result of negligence or for any other cause.

I/We agree to provide proof of legal residence and age upon request and understand that our child (candidate) must be eligible under the residence and age regulations of LSTAA and/or its affiliated leagues of play to participate. I/We agree to furnish an acceptable and certified birth certificate of the above-named candidate and/or proof of residency documents upon requested as determined by the LSTAA Board of Directors.

Finally, I/We attest that we are the legally recognized parent or guardian of the participant and hereby take responsibility that the information provided is accurate and true to be best of my/our knowledge.

Signature: _____ Date: _____

For League Use Only

| | | | | |
|---|---|--|--|--|
| Birth Certificate <input type="checkbox"/> Yes <input type="checkbox"/> No | Medical Release <input type="checkbox"/> Yes <input type="checkbox"/> No | Proof of Residency <input type="checkbox"/> Yes <input type="checkbox"/> No | New Player <input type="checkbox"/> Yes <input type="checkbox"/> No | Level Assigned <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
|---|---|--|--|--|



Medical Release Form

Lower Swatara Township Athletic Association

Player Information

Player Name: _____ Date of Birth: _____

Parent/Guardian Information

Parent/Guardian Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: _____ Cell Phone: _____

Home Phone: _____

Parent/Guardian Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: _____ Cell Phone: _____

Home Phone: _____

Primary Emergency Contact (other than parent(s) above)

| Name | Phone | Relationship to Player |
|-------|-------|------------------------|
| _____ | _____ | _____ |

This individual will be contacted if the parent/guardian(s) cannot be reached.

Insurance Information:

| Company | Policy # | Group # |
|---------|----------|---------|
| _____ | _____ | _____ |

List Player's allergies/medical conditions

(Please include existing conditions that require maintenance medication & medication list.)

I/We the undersigned, parent or legal guardian of the participant, a minor, hereby authorize the supervising adults (including managers and coaches) or volunteered parents acting in the capacity of activity supervisors, as my Agents, to consent to medical, surgical or dental examination and/or treatment if in the judgment of any duly certified medical professional that such medical, surgical or dental examination and/or treatment is necessary and/or recommended. In case of emergency, I/We hereby authorize treatment and/or care at any hospital or medical facility that is deemed necessary.

Signature: _____ Date: _____

For League Use Only

Level Assigned: _____ Manager: _____