Five Cities Youth Baseball

PO Box 2806, Pismo Beach, CA 93448
www. fivecitiesyouthbaseball.com

Registration Form

Player Name: **Birth Date:** **League Age:** **Gender:**

Address: **City:** **State:** **Zip:**

Home Phone: **Cell Phone:**

Email Address:

Returning Player: YES / NO (If yes no proof of birth or residency is required.) **Division Last Year:**

School Name: **Grade:** **Team Last Year:**

Do you have a sibling playing: YES / NO **If yes, name of sibling:**

Division Preference	Min Age	Max Age
Majors / Minors	10	12
Farm	9	11
Rookie	6	8
Tee Ball	4	6

Special Instructions

Shirt Size - (Circle One)

Youth Small Adult Small
Youth Medium Adult Medium
Youth Large Adult Large
Other _____ Adult X-Large
Adult XX-Large

Parent/Guardian Information

Guardian Name: **Phone:** **Relationship:**

Address: **City:** **State:** **Zip:**

Guardian Name: **Phone:** **Relationship:**

Address: **City:** **State:** **Zip:**

Emergency Contact: **Phone:** **Relationship:**

Yes, I would like to volunteer:(circle one) Manage, Coach, Scorekeeper, Team Mom, Board Member, Other

If yes, please fill out the "Volunteer Application"

League Use Only

Date Paid: **Cash** **Check** **Check Nbr:**

Player Fee: **Other Fee:** **Total Paid:**

COMPLETE BOTH SIDES OF FORM

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Medical Release

Medical Information

Family Physician: **Phone:**

Dentist Name: **Phone:**

Preferred Hospital:

Insurance Carrier: **Policy Number:**

Medical History: Allergies, Medications, Special Conditions, etc

Medical Authorization

PART I GRANT OF CONSENT

In the event reasonable attempts to contact the parents or guardians have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by preferred Dr.(2), or preferred Dentists or in the event designated Dr. or Dentist is not available, by another licensed physician or dentist; and (2) the transfer of the child to preferred hospital or any hospital reasonably accessible.

NOTE: This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring in necessity for such surgery are obtained BEFORE the surgery IS PERFORMED.

Participant Name: (Print Name)

Parent/Guardian/Custodian: **Date:**

Signature

PART II REFUSAL OF CONSENT

(Do not complete if Part I has been completed)

I do NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish that Five Cities Youth Baseball to take no action, or perform the following actions:

Actions to be Performed:

Participant Name: (Print Name)

Parent/Guardian/Custodian: **Date:**

Signature

COMPLETE BOTH SIDES OF FORM