

Keene Cal Ripken Baseball Association

2009 Season Registration Form

Player Name: _____ **Phone:** _____ **Birth Date:** ____/____/____
Address: _____ **City:** **Keene or Surry** , NH **03431**
Gender Male Female *circle one*

Email Address: _____
Guardian Name: _____ **Phone:** _____
Guardian Name: _____ **Phone:** _____
Emergency Contact: _____ **Phone:** _____
School Name: _____ **Grade:** _____

Parent Approval to Contact Participant via Email (for children under the age of 13) Yes No
Relationship: _____
Relationship: _____
Relationship: _____

Division Preference	Min Age	Max Age
<input type="checkbox"/> Tee Ball League	5	6
<input type="checkbox"/> Pee Wee League	6	7
<input type="checkbox"/> Rookie League	8	9
<input type="checkbox"/> Junior League	9	12
<input type="checkbox"/> Senior League	10	12
<input type="checkbox"/> Summer League 10-11-	10	12
<input type="checkbox"/> Summer League 7- 8- 9	7	9



Team Last Year: _____

Sibling(s) ? yes / no **League:** _____

League Use Only	
Date Paid: ____/____/____	
Cash	Check
<input type="checkbox"/>	<input type="checkbox"/>
Chk Nbr: _____	
Player Fee:	\$60 \$45
Other Fees:	
Total Paid:	_____

Medical Information

Preferred Doctor Name: _____ **Phone:** _____
Preferred 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 a 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 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 KCRBA or perform the following actions:

Actions to be Performed:

Participant Name: _____ **Print Name**

Parent/Guardian/Custodian: _____ **Date:** _____
Signature