Keene Cal Ripken Baseball Association

2009 FALL BALL Registration Form

Player Name: _____ **Phone:** _____

Address: _____ **Citv:** _____ **, NH** **03431**

Gender [ ] Male [ ] Female

Email Address: _____

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

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

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

School Name: _____ **Grade** _____

MIN Age @ 4/30/10	MAX Age @ 4/30/10	Division Preference	Age @April 30, 2010
10	12	Fall Senior League	
9	10	Fall Junior League	

Birth Dat ___/___/___

Shirt Size	
[ ]	Youth Small
[ ]	Youth Medium
[ ]	Youth Large
[ ]	Adult Small
[ ]	Adult Medium
[ ]	Adult Large

Spring Team: _____

Sibling(s) ? within KCRBA yes / no League: _____

Request for Sibling/ Friend Team Assignment_____

We make efforts to align players with requests but weigh importance on Transportation

League Use Only

Date Paid: ___/___/___

Cash [ ] Check [ ]

Chk Nbr: _____

Player Fee:	$25	$40
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 any treatment deeme in the event designated Dr. or Dentist is not available, by another licensed physician or dentist; ar

NOTE: This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring in necessity for such sur 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 to take nc

Actions to be Performed:

Participant Name: _____

Print Name

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

Signature