2017 Holgate T-Ball Registration Form

Ages 5-7 (4 Years of age permitted to play with Commissioner's approval)

Player's Name_____ Parent Name(s) _____

Player's Date of Birth_____ Age_____

Street_____ City_____ State_____ Zip_____

Telephone Number_____ Cell Phone Number_____

Email Address_____ Can Text Cell Phone ☐ Yes ☐ No

T-ball Sign-Up will be held in the School Atrium on **February 27, 2017 5:00-6:30pm**. The registration form and fees will be collected at the time of sign-up. The Emergency Medical Form is on the back of registration. Please complete both sides of form before turning in.

Fees: $25.00 Checks payable to: Holgate T-ball Association

T-Shirt Size:

It is very important that you select the correct size for your child. There are no exchanges or returns.

___Youth S (4-5) ___Youth S (6-8) ___Youth M (10-12) ___Youth L (14-16)

Please indicate (if applicable) the color of your child's team last year:_____

Hats:

If you would like a hat for the 2017 year please indicate your preference, there will be a **$5.00** charge for a hat, they will be purple with a yellow "H". YES NO

Car Pool:

If you need to make arrangements to be on the same team as another child, please write the name(s) of those children below. We will try to honor all requests but cannot make any guarantees. If there are siblings, please indicate that below as well.

Child's Name	Sibling: Y or N	Child's Name	Sibling: Y or N

Parent Signature: _____ **Date:** _____

I'm interested in Coaching: ☐ Head Coach ☐ Assistant Coach ☐ Willing to help

*Coaches will be contacted by Derek Williams. ☐ Head Coach T-Shirt Size _____

Emergency Medical Authorization Form

Player's Name_____ Telephone Number (____)_____

Street_____ Cellphone Number (____)_____

City_____ State_____ Zip Code_____

Residential Parent or Guardian:

Mother's Name_____ Day Time Phone (_____)_____

Father's Name_____ Day Time Phone (_____)_____

Other's Name_____ Relationship_____ Day Time Phone (_____)_____

Name of Relative or Childcare Provider:

_____ Relationship_____ Phone Number (_____)_____

Street_____ City_____ State_____ Zip Code_____

Part I: To Grant Consent:

I hereby give consent for the following medical care providers and local hospitals to be called:

Physician_____ Telephone Number (____)_____

Dentist_____ Telephone Number (____)_____

Local Hospital_____ Telephone Number (____)_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the (1) administration of any treatment deemed necessary by above-named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does NOT cover major surgery unless the medical options of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken and any physical impairment to which a physician should be alerted:

_____

_____

_____

Date_____ Signature of Parent or Guardian_____

Part II: Refusal to Consent

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the authorities to take the following action:

_____

_____

_____

Date_____ Signature of Parent or Guardian_____