Holgate Baseball 2017

Player's Name ______________________ **Parent** ______________________

Date of Birth ______________________ **Age** __________

Address ____

Home Phone ________________ **Cell #** ______________________

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* Sign up - February 27 will be held in the school atrium from 5:00 to 6:30
* Cut off date to sign up March 15th any forms turned in after March 15th will be $10 extra
* If you cannot attend sign up day, please send check to Brian Bok @ 18-664 Co Rd H, Holgate Ohio 43527. Checks made out to HOLGATE BASEBALL ASSOCIATION
* Fees MUST be paid by April 1st for all players.
* If you do not want to work in a concession stand, an additional $10 can be donated to avoid working.
* Fees - 1st child $50 any additional child $35

Parent Signature ______________________ **Date** ______________________

Shirt Size YS YM YL AS AM AL AXLG

<u>* Please be sure of shirt size. There are no exchanges or returns.</u>

I AM INTERESTED IN COACHING ______________________ ***Y N***

Brian Bok 419-438-1138 holgatebaseballassoc@gmail.com
Bill Leaders 419-906-5817 bill.leaders5817@gmail.com
Tom Kelly 419-615-7785 kelly.tj79@yahoo.com

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:

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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:

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Date________________________ Signature of Parent or Guardian______________________________________