2017 Holgate Girls Softball Registration Form

Join the Holgate Summer Softball Page on Facebook!!

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

Softball Sign-Up will be held in the School Atrium **Monday, February 27, 2017 at 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.

Leagues and Fees:

___8u: Ages 7-8 (Can Not turn 9 before January 1, 2017) Fees are $20.00

___10u: Ages 9-10 (Can Not turn 11 before January 1, 2017) Fees are $25.00

___12u: Ages 11-12 (Can Not turn 13 before January 1, 2017) Fees are $30.00

___14u: Ages 13-14 (Can Not turn 15 before January 1, 2017) Fees are $30.00

Make checks payable to "Holgate Girls Softball"

T-Shirt Size:

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

___Youth S (6-8) ___Youth M (10-12) ___Youth L (14-16)
___Adult Small ___Adult Medium ___Adult Large ___Adult X-Large

Visor:

Players may purchase a purple team visor for $8.00. Visor purchases are optional.
___**Purchase** a visor for my daughter. ___**Do Not Purchase** a visor for my daughter.

Parent Signature: ________________________________ **Date:** ____________________

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

*Coaches will be contacted by Carla Blaker. ☐ **Head Coach T-Shirt Size** ____________________

If you have any questions, please contact Carla Blaker at (419) 297-8151 cblaker26@hotmail.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____