



REGISTRATION FORM

*Please Print All Information

Name: _____ Age: _____ DOB: _____ M: ___ F: ___

Address: _____ City: _____ Zip: _____

Ph. #: _____

2011-2012 Grade: _____ School: _____

Division: Div I: ___ Div II: ___ Div. III: ___ Div. IV: ___

Jersey Size (Mandatory): YS ___ YM ___ YL ___ AS ___ AM ___ AL ___ AXL ___ AXXXL ___

Father's Name: _____ Father's Cell: _____

Mother's Name: _____ Mother's Cell: _____

Family Physician: _____ Physician Ph #: _____

Insurance Carrier: _____ Policy: _____

Emergency Contact

Name: _____ Relationship: _____

Hm. #: _____ Cell #: _____

Name: _____ Relationship: _____

Hm. #: _____ Cell #: _____

Any Pre- Existing Health Problems

If the above named person needs emergency treatment and neither parent nor the family physician can be contacted, consent is hereby granted for such emergency treatment as may be considered necessary in the opinion of the attending physician.

Parent/Guardian Signature: _____ Date: _____

Staff Use Only

Amount Paid: _____

Staff Initials: _____

Type of Payment: _____

Receipt: _____