

A.H.Y.A.A. / Adult Registration Waiver Form (Boy's Baseball Majors Second Season) 2009

Parent's Name (Please Print) _____ REG FEE \$ _____

Address _____ INS FEE \$ _____

City _____ Zip _____ AMT PD \$ _____

Phone # _____ Cell # _____ CASH _____ CHK # _____

Name _____ Grade Completed _____ School _____

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(GRADE COMPLETED AS OF JUNE, 2009)

Baseball Fee: \$35.00 each participant.

*****Registration deadline 7/01/09*****

Insurance Fee: \$7.00 additional for those participants who did not participate in regular in-house play.

Returned Checks: \$20.00 will be charged for any returned check(s).

Eligibility: Boys who have just completed 5th & 6th grade; residing within village and/or park district of Arlington Heights and/or attending school with Arlington Heights children.

WILLING TO MANAGE OR COACH _____ (check) VACATION DATES _____

The undersigned parent/guardian of child named above, for and in consideration of such child being permitted to participate in A.H.Y.A.A. activities do hereby release and forever discharge A.H.Y.A.A., its officers, directors, supervisors, volunteers and participants, and all other persons, firms, corporations, associations, or other entities from any and all claims, actions, causes of action, demands, rights, damages and costs whatsoever which may hereafter accrue on account of or in any way growing out of any and all known or unknown, foreseen or unforeseen bodily or personal injuries and property damages, and the consequences thereof, arising out of or resulting from participation in A.H.Y.A.A. activities, including but not limited to, practices, games, contests, and transportation to or from such activities.

PARENT/GUARDIAN SIGNATURE: _____

To Whom It May Concern:

Release dates 7/15/2009 - 9/01/2009

As a parent/guardian of the child named below, I do herewith authorize the treatment by a qualified and licensed medical doctor of the child named below in the event of medical emergency which in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me at the number below.

First Name: _____ **Last Name** _____ **Son / Daughter**
(Please Print) (Circle One)

This release is completed and signed of my own free will with the purpose of authorizing medical treatment under emergency circumstances.

Signed: _____ Phone # _____

Physician or Provider: _____ Phone # _____

Specific medical allergies, chronic illnesses or other conditions: _____

Alternate contact: _____ Phone # _____

NOTE: A separate medical release must be filled out for every registrant !!!