A.H.Y.A.A. / Adult Registration Waiver Form (Boy's Baseball Juniors Second Season) 2008

Parent's Name (Please Print) ____ **REG FEE $ ___________**

INS FEE $ ____________

Address ____Zip________________ **AMT PD $ ____________**

Phone # _________________________ **CASH ____CHK # _____**

Name _______________________ Grade Completed _______ School ___________________

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Baseball Fee: (**GRADE COMPLETED AS OF JUNE, 2008)** $35.00 each participant.

Registration deadline 7/1/08

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 3rd & 4th 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 7/15/2008 - 9/01/2008

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: ____
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Alternate contact: ____Phone #____________________

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