

**BEAMSVILLE MINOR BASEBALL ASSOCIATION
2011 REGISTRATION**

Player Information

Name: _____ Birthdate: _____
(Day / Month / Year)

Mailing Address: _____

Telephone Number: _____

Level Played Last Year: _____

2011 Registration (Indicate one):

	Year of Birth	Fees
T-Ball	2004 – 2006	\$100.00
Rookie Ball	2002 – 2003	\$140.00
Mosquito	2000 – 2001	\$140.00
Pee Wee	1998 – 1999	\$140.00
Bantam	1996 – 1997	\$160.00
Midget	1993 – 1995	\$160.00

Parents / Guardians

Name: _____ Telephone Number: _____

Address: (if different than above) _____

Email: _____

Children's Fitness Tax Credit Receipt Requested **Email address required to receive receipt**

Please indicate any areas you are willing to provide support with:

Coach: _____ Assistant Coach: _____ Manager: _____ Other: _____

We hereby release and discharge Beamsville Minor Baseball Assoc., it's members and coaches from liability and responsibility for any injury to our child, however caused while involved in the baseball program.

Parents / Guardians Signature: _____

-SEE OVER-

OFFICE USE ONLY

Division: _____ Fee: _____

Cash: _____ Cheque: _____ Bank and Number _____

PLAYER INFORMATION

MOTHER'S NAME: _____ Work Number: _____

FATHER'S NAME: _____ Work Number: _____

CONTACT PERSON IN CASE OF EMERGENCY (If parents are unavailable)

Name: _____ Phone Number: _____

Doctor: _____ Phone Number: _____

Health Number: _____

Please provide the following information pertaining to your child:

Allergies	Yes _____ No _____	Asthma	Yes _____ No _____
Wears Glasses	Yes _____ No _____	Wears Contacts	Yes _____ No _____
Diabetic	Yes _____ No _____	Epileptic	Yes _____ No _____
Hearing Problem	Yes _____ No _____	Heart Condition	Yes _____ No _____
Regular Medication	Yes _____ No _____	Medic Alert Bracelet	Yes _____ No _____
Recent Operations	Yes _____ No _____	Hospitalized last 12 mo.	Yes _____ No _____

Does your child have any health problems that may interfere in his/her participation in the minor baseball program? (Provide details to any questions you answered "yes" to, as well)

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE THE TEAM MANAGEMENT WITH ANY/ALL CHANGES RELATED TO THE ABOVE NOTED MEDICAL ISSUES OF MY CHILD AS SOON AS POSSIBLE.

IN THE EVENT THAT NO ONE CAN BE CONTACTED, TEAM MANAGEMENT WILL ADMIT MY CHILD TO THE HOSPITAL IF DEEMED NECESSARY.

I HEREBY, AUTHORIZE THE PHYSICIAN AND NURSING STAFF OF ANY EMERGENCY UNIT TO UNDERTAKE EXAMINATION, INVESTIGATION AND NECESSARY TREATMENT OF MY CHILD.

(Date)

Parent / Guardian Signature