

West Boca Raton Softball Association

Registration Form

Player Name: _____	Phone: _____	Birth Date: _____
Address: _____	City: _____	Postal Code: _____
Email Address(es): _____	_____	_____
Guardian Name: _____	Phone: _____	Relationship: _____
Guardian Name: _____	Phone: _____	Relationship: _____
Emergency Contact: _____	Phone: _____	Relationship: _____
School Name: _____	Grade: _____	

To receive updates from WBRSA, please register at www.closingalerts.com. We utilize this service to communicate information such as field closings, registration dates, clinics, etc. to our members.

Division Preference	Min Age	Max Age	Shirt Size	Pants Size	
<input type="checkbox"/> T-ball	4	6	<input type="checkbox"/> Youth Small	<input type="checkbox"/> Youth Small	<div style="text-align: center; font-size: small;">League Use Only</div> Date Paid: ___/___/___ <input type="checkbox"/> Cash <input type="checkbox"/> Check Chk Nbr: _____ Player Fee: _____
<input type="checkbox"/> 8 Under	6	8	<input type="checkbox"/> Youth Medium	<input type="checkbox"/> Youth Medium	
<input type="checkbox"/> 10 Under	8	10	<input type="checkbox"/> Youth Large	<input type="checkbox"/> Youth Large	
<input type="checkbox"/> 12 Under	10	12	<input type="checkbox"/> Adult Small	<input type="checkbox"/> Adult Small	
<input type="checkbox"/> 16 Under	12	16	<input type="checkbox"/> Adult Medium	<input type="checkbox"/> Adult Medium	
			<input type="checkbox"/> Adult Large	<input type="checkbox"/> Adult Large	
			<input type="checkbox"/> Adult X-Large	<input type="checkbox"/> Adult X-Large	
			<input type="checkbox"/> Adult XX-Large	<input type="checkbox"/> Adult XX-Large	
			<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	

Jersey Number Preference _____

Medical Information

Preferred Doctor Name: _____	Phone: _____
Preferred Dentist Name: _____	Phone: _____
Preferred Hospital: _____	
Insurance Carrier: _____	Policy Number: _____

Medical History: Allergies, Medications, Special Conditions, etc:

Medical Authorization

PART I GRANT OF CONSENT

In the event reasonable attempts to contact the parents or guardians have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by preferred Dr. or preferred Dentists or in the event designated Dr. or Dentist is not available, by another licensed physician or dentist; and (2) the transfer of the child to preferred hospital or any hospital reasonably accessible.

NOTE: This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring in necessity for such surgery are obtained BEFORE the surgery IS PERFORMED.

Participant Name: _____
Print Name

Parent/Guardian/Custodian: _____ Date: _____
Signature

PART II REFUSAL OF CONSENT (Do not complete if Part I has been completed)

I do NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish that West Boca Raton Softball Association to take no action, or perform the following actions:

Actions to be Performed: _____

Participant Name: _____
Print Name

Parent/Guardian/Custodian: _____ Date: _____
Signature