

Abington Raiders

Registration Form

Player Name: _____ Phone: _____ Birth Date: _____
 Address: _____ City: _____ State/Prov. _____
 Gender Male Female Height _____ Weight _____ Postal Code _____
 Email Address: _____
 Guardian Name: _____ Phone: _____ Relationship: _____
 Guardian Name: _____ Phone: _____ Relationship: _____
 Emergency Contact: _____ Phone: _____ Relationship: _____
 School Name: _____ Grade: _____ Jersey Number Preference _____

Division Preference	Min Age	Max Age	Shirt Size	Pants Size	
			<input type="checkbox"/> Youth Small <input type="checkbox"/> Youth Medium <input type="checkbox"/> Youth Large <input type="checkbox"/> Adult Small <input type="checkbox"/> Adult Medium <input type="checkbox"/> Adult Large <input type="checkbox"/> Adult X-Large <input type="checkbox"/> Adult XX-Large <input type="checkbox"/> Other _____	<input type="checkbox"/> Youth Small <input type="checkbox"/> Youth Medium <input type="checkbox"/> Youth Large <input type="checkbox"/> Adult Small <input type="checkbox"/> Adult Medium <input type="checkbox"/> Adult Large <input type="checkbox"/> Adult X-Large <input type="checkbox"/> Adult XX-Large <input type="checkbox"/> Other _____	League Use Only Date Paid: _____ <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Online <input type="checkbox"/> Other Chk Nbr: _____ Player Fee: _____ Other Fees: _____ Total Paid: _____ Bal. Due: _____ <input type="checkbox"/> BC Verified <input type="checkbox"/> Residency Verified <input type="checkbox"/> Medical Authorization <input type="checkbox"/> Photo ID Today's Date _____

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.(2), 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 Abington Raiders to take no action, or perform the following actions:

Actions to be Performed: _____

Participant Name: _____
Print Name
 Parent/Guardian/Custodian: _____ Date: _____
Signature