

2010 Player Registration Form

Fairport Little League
PO Box 334
Fairport NY 14450



Player Information			
Last Name	First Name	Middle Init.	Date of Birth
Street Address			City
Zip		Phone #	E-Mail
League/Age Group you are registering for:		Check one: <input type="checkbox"/> Returning Player <input type="checkbox"/> New Player (will require a copy of birth certificate)	Check one: Baseball (Boys/Girls) <input type="checkbox"/> Male <input type="checkbox"/> Female Girls Softball <input type="checkbox"/> Female
The following are eligible to tryout or request to play up. Check if interested _____		<ul style="list-style-type: none"> • 10 yr olds to International or Bronco baseball • 11-12 year olds tryout for Bronco baseball • 8 year olds to Softball Minors • 10 year olds tryout for Softball Majors 	

Parent / Guardian Information			
Father	Last Name	First Name	Middle Init.
	E-Mail(s)		
Mother	Last Name	First Name	Middle Init.
	E-Mail(s)		
Volunteering? I am (we are) willing to: (circle all that are appropriate)			
Manage	Coach	Team Parent	Field Maintenance
Booster Club			
Parent Authorization I, a parent or guardian of the above named candidate for a position on a Fairport Little League team, hereby give my approval to his/her participation in any and all Fairport Little League activities. I assume all risks and hazards incidental to such participation including transportation to and from the activities; and I do hereby waive, release, absolve, indemnify, and agree to hold harmless the local League, the organizers, sponsors, supervisors, participants, and persons transporting my son/daughter to or from activities, for any claim arising out of injury to my son/daughter whether the result of negligence or for any other cause, except to the extent and in the amount covered by accident or liability insurance. I agree to return upon request, the uniform and other equipment issued to my son/daughter, in the condition received, except for normal wear and tear.			
			_____ Parent or Guardian Signature

Parent / Guardian Medical Release			
In case of emergency, if the family physician cannot be reached, I hereby authorize my child to be treated by another available qualified and licensed physician.			Today's Date
Player Last Name	First Name	Middle Init.	Date of Birth
Family Physician Name	Phone		Family Insurance Provider
			<input type="checkbox"/> Blue Cross <input type="checkbox"/> Preferred Care <input type="checkbox"/> Other. Which? _____
Family Physician Street Address	City/Town	Zip	
Player Allergies			
Any Drugs/Medication being used			Date of last Tetanus Toxoid Booster
Current medical problems a physician should know about.			
			_____ Parent or Guardian Signature