

2011-2012 Bellbrook Wee Eagles Basketball Registration

Player's Name _____ Home Phone # _____

(Circle One) Boy or Girl Team Grade _____ Grade in School _____ Birth Date _____

Is your child a resident of or attends Sugarcreek Local School district? (Circle One) Yes No

Mother _____ Cell Phone # _____

Father _____ Cell Phone # _____

Address _____ City _____ Zip _____

Email 1: _____ Email 2: _____

In the event of joint custody or shared parenting please include second address below:

Parent/Guardian Name _____

Address _____ City _____ Zip _____

Medical Consent - Parental Instructions Concerning Medical Treatment

Is your child on medication? (Circle One) Yes No If yes, list medications: _____

Drug Sensitivities: _____ Allergies: _____

List physical impairments, hospitalization, blackouts, participation restrictions, surgery, or serious injury/illnesses your child has had:

Insurance Company: _____ Policy Number: _____

CHECK ONLY ONE BOX BELOW

If my child needs medical treatment, while participating, it is my wish that I am contacted *before* any medical procedures are performed, unless immediate treatment is necessary to save his life or prevent permanent injury.

OR

If my child needs medical treatment, while participating, it is my wish that the treatment be begun while efforts are being made to contact me. So that treatment is not delayed, I consent to any medical procedures that the physicians believe are needed, on the understanding that efforts will continue to contact me. I accept responsibility for all costs related to such treatment.

Photo Release - CHECK ONLY ONE BOX BELOW

Yes, I give permission for the Bellbrook Wee Eagles Organization to include athlete's photos and video and personally identifiable pictures in the school and/or district newsletters, local newspapers and/or the Wee Eagle website.

OR

No, I do not give permission for the Bellbrook Wee Eagles Organization to include athlete's photos and videos and personally identifiable pictures in the school and/or district newsletters, local newspapers and/or the Wee Eagle website.

By signing this form you understand the following: (1) That the Bellbrook Wee Eagles is a non-profit youth sports organization completely supported by the efforts of volunteers and, (2) It is designed to provide school age children residing in or attending the Sugarcreek Local School District with opportunities to practice and compete in various athletic events and, (3) The organization is bound by the rules and regulations of its league and tournament affiliations as well as its own policies and charter.

By signing this form you further agree to release the Bellbrook Wee Eagles (Including Board Members, Directors, Coaches and all other volunteers), The Sugarcreek Local Schools, and all the aforementioned agents, officers, and representatives of, from any claim in the event of injury to person or damage of property.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Dayton Metro Conference Youth Basketball - Child Release Agreement

I, the undersigned, being the parent and/or legal guardian of _____ (child's name) a minor, understand the risks and possibility of physical injury associated with basketball, and in consideration of accepting my child for the Dayton Metro Conference, all its member programs including the Bellbrook Wee Eagles, all its facilities owners and/or managers, including the Sugarcreek Local School District (facilities owner and/or manager), and all employees, sponsors, and associated personnel, against any claim by or on behalf of my child as a result of my child's participation in the Dayton Metro Conference youth basketball program, activities, and/or being transported to or from same which transportation I hereby authorize.

Parent/Guardian Name: _____

Signature: _____ Date: _____

Address: _____

City: _____ State: OH Zip: _____

Consent for Medical Treatment (minor)

As the parent or legal guardian of _____ (child's name), I hereby give my consent for emergency medical care prescribed by a duly licensed doctor of medicine or doctor of dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent. (Failure to sign indicates you do not give consent.)

Name: _____

Signature: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers:

Home: _____ Work: _____

Cell (s): _____ Emergency: _____