

2017

Town of Cambria Baseball / Softball Registration Form

Cambria House League Fees:

Resident: \$40 first child; \$40 second child; \$20 each additional child
Non-Resident: \$60 first child; \$60 second child; \$30 each additional child

Cambria Travel League Fees:

Boys Travel Team - \$100
Girls Travel Team - \$75

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_
(mm/dd/yy)

Address: \_\_\_\_\_ City / State / Zip \_\_\_\_\_

Email Address: \_\_\_\_\_ Parent/Guardian Name(s): \_\_\_\_\_

Interested in coaching: \_\_\_Y\_\_\_N Birth Certificate Presented: \_\_\_Y\_\_\_N- on file, played last year

Did you play last year? \_\_\_Y\_\_\_N Team Name: \_\_\_\_\_ / Coach: \_\_\_\_\_

Cambria House Leagues

- T-Ball (4-6 co-ed)
Midgets (7 & 8 co-ed)

Boys

Girls

- Minors (9-10 boys) Softball (8-11 girls)
Majors (11-12 boys) Softball (12-14 girls)
Babe Ruth (13-15 boys) Pony Tail (15-18)

Shirt size: Child: \_\_\_S\_\_\_M\_\_\_L
Adult: \_\_\_S\_\_\_M\_\_\_L\_\_\_XL

Age as of Jan. 1st: \_\_\_\_\_

Cambria Travel Leagues

- Boys Travel A Team
16-20

Player cannot be 20 before June 1st

(Try-Out needed)

- Girls Softball Travel Team- 12U
Girls Softball Travel Team - 14U
Girls Softball Travel Team - 16U
Girls Softball Travel Team - 18U

Age as of Jan. 1st: \_\_\_\_\_

PERMISSION WAIVER:

I GIVE PERMISSION FOR MY CHILD \_\_\_\_\_, TO PARTICIPATE IN THE TOWN OF CAMBRIA BASEBALL PROGRAM. I UNDERSTAND AND HEREBY RELEASE AND FOREVER DISCHARGE ANY AND ALL RIGHTS AGAINST THE TOWN OF CAMBRIA, THE RECREATION COMMITTEE, THE COACHES, ALL EMPLOYEES OF THE TOWN OF CAMBRIA AND THE PEKIN FIRE COMPANY FOR INJURIES TO THE ABOVE NAMED PERSON OR PROPERTIES DURING ANY ACTIVITY RELATED TO PARTICIPATION IN THE BASEBALL PROGRAM.

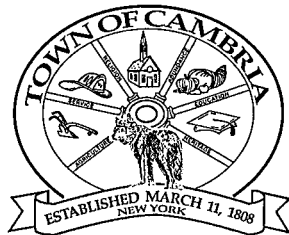
I ALSO ACKNOWLEDGE THAT IT IS MY RESPONSIBILITY TO REVIEW AND ENFORCE THE RULES OF THE PROGRAM WITH MY CHILD AND WILL PROMOTE GOOD SPORTSMANSHIP ETHICS BOTH ON AND OFF THE FIELD WHILE PARTICIPATING IN THIS PROGRAM.

DATE: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

OFFICE USE ONLY

Receipt # \_\_\_\_\_
Cash \_\_\_\_\_ Check # \_\_\_\_\_
Credit Card \_\_\_\_\_



## 2017 Town of Cambria Individual Health Record & Medical Permit

NAME \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

PARENT/ GUARDIAN: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_

PHONE: \_\_\_\_\_

RELATIONSHIP TO PARTICIPANT: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

PHONE: \_\_\_\_\_

FAMILY MEDICAL / HOSPITAL INSURANCE CARRIER: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_

DATE OF LAST HEALTH EXAMINATION: \_\_\_\_\_

DATE OF LAST TETANUM IMMUNIZATION: \_\_\_\_\_

### **ILLNESSES AND INJURIES**

- ASTHMA     BLEEDING/ CLOTTING DISORDER     DIABETES  
 HEART DEFECT/ DISEASE     HYPERTENSION     MUSCULOSKELETAL DISORDERS  
 SEIZURES     OTHER (SPECIFY)

OPERATIONS AND OR SERIOUS INJURIES (WITH DATES)

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### **ALLERGIES**

- ANIMALS     FOOD     HAY FEVER     INSECT STINGS  
 MEDICINE     PLANTS     POLLEN     SUN  
 OTHER (SPECIFY)

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**TOWN OF CAMBRIA  
INDIVIDUAL HEALTH RECORD AND MEDICAL PERMIT**

**OTHER HEALTH CONDITIONS**

- EMOTIONAL DISTURBANCES       FAINTING       MENSTRUAL CRAMPS  
 HEARING IMPAIRMENT       WEARS GLASSES       WEARS CONTACT LENSES  
 OTHER (SPECIFY) \_\_\_\_\_

Please explain all items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also indicate any activities to be restricted:

\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS**

Please list all medications participant is currently taking and for what reason:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL ATTENTION AUTHORIZATION**

In and EMERGENCY, should it happen that we, the parents and/or guardians of \_\_\_\_\_ cannot be located promptly, HEREBY AUTHORIZE THE REPRESENTATIVE/ SUPERVISING ADULT (coach or site leader) of the TOWN OF CAMBRIA BASEBALL/ SOFTBALL/ T-BALL PROGRAM OR THE SUMMER RECREATION PROGRAM to be my (our) agent in authorizing any hospital/ physician deemed advisable by, and rendered under the general supervision of any licensed medical doctor on the staff of any hospital for my child/ legal ward or myself.

**EFFECTIVE DATE: FROM: \_\_\_\_\_ TO: \_\_\_\_\_**

**Signature of parent/ guardian and/or adult participant:**

\_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\* NOTE: If there is religious opposition to medical treatment or immunization, you must supply a written statement indicating the religious beliefs. This statement must be signed and dated.**

**THIS FORM MUST BE IN THE POSSESSION OF THE SUPERVISING ADULT AT ALL CAMBRIA BASEBALL/ SOFTBALL/ TEE-BALL/ ACTIVITIES AND/OR SUMMER RECREATION PROGRAM ACTIVITIES IN CASE OF A MEDICAL EMERGENCY!!!**