

Bloom-Carroll Youth Athletics (BCYA)

P.O. Box 191
Lithopolis, OH 43136

SIGN UPS POSTMARKED AFTER 3-3-2007 WILL BE CHARGED A \$20.00 LATE FEE

Player's name _____ Birth Date _____ Age _____
Lives with _____ (Father/Mother/Both) Sex: Male Female
Father's Name: _____ Mother's Name: _____
Address: _____ Address: _____
City/State/Zip: _____ City/State/Zip: _____
Home Phone: _____ Home Phone: _____
Work/Cell: _____ Work/Cell: _____
E-Mail _____ E-Mail _____

ALL PARENTS ARE ASKED TO HELP IN AT LEAST ONE OF THE FOLLOWING AREAS
Please Circle
Coach Assistant Coach Umpire Concession Stand Team Parent Diamond Prep
_____ check here if you do not wish to help in any of the above ways. \$20.00 will be added to your fees.

____ I have a company
that would be interested
in becoming a BCYA
sponsor. Please contact
me with any
information.

ALL PARENTS ARE ASKED TO PARTICIPATE WITH A FUND RAISER. More info to come
_____ check here if you do not wish to participate in our fund raiser. \$20.00 will be added to your fees.

Please check the program your child qualifies for:
(We are unable to guarantee placement of players on certain teams/coaches or with friends)

_____ Tee-Ball (for children who will be 5 years old before 9-1-2007 but not older than 7 before 7-31-07\$40.00

Has this child played before? No Yes if yes, for what team/coach _____

Uniform Sizes: See sample shirts for correct sizing
Shirt YS YM YL AS AM AL AXL

WAIVER, RELEASE, AND HOLD HARMLESS AGREEMENT

Players Release and Permission,

I, the undersigned, hereby consent and agree that the herein named child is physically able and may be an active participant with the Bloom-Carroll Youth Athletics. In consideration of the acceptance of my entry as a participant in the Bloom-Carroll Youth Athletics ball program, I do hereby for myself, my heirs, executors, and administrators waive, release and forever discharge any and all rights and claims for damage which I may have or which may accrue to me against the Bloom-Carroll Youth Athletics, its Board of directors, the Sponsors, the administrators of the playing field, or all of their respective officers, agents or representatives, successors, and/or assigns for any and all damages which may be sustained and suffered by me in connection with any said association with or my entry and/or arising out of my travel to participation in and return from said games, exhibitions, or practice sessions conducted during the current playing year.

In consideration for such recreation and training being afforded our child, we do hereby release and discharge the Bloom-Carroll Youth Athletics, its Board of Directors, the coaches, assistants and their appointees, any and all of them, from any claims, liabilities, damages, or demands for injuries to persons or property sustained by the named child, and resulting from his/her participation, and practice, or play in and with the aforementioned ball program. THIS REGISTRATION DOES NOT GUARANTEE PLACEMENT ON A TEAM. BCYA may refund the registration fee at any time without further obligation to allow the player to participate.

NO MEDICAL INSURANCE OR OTHER INSURANCE IS PROVIDED BY THE BCYA. THE UNDERSIGNED ASSUMES FULL RESPONSIBILITY FOR OBTAINING ALL NECESSARY INSURANCE.

Parent Signature _____ Date _____ Additional Items Total \$ _____

Note: We are unable to guarantee placement of players on certain teams or with friends.

Paid with Check # _____ \$ _____, Cash _____ Rec'd by _____

**BLOOM-CARROLL YOUTH ATHLETICS
2007 EMERGENCY MEDICAL AUTHORIZATION**

Player's Name _____
Address _____
Birth Date _____ Telephone No. _____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while participating in the Bloom-Carroll Youth Athletics program, when parents or guardians cannot be reached.

Part 1 or Part 2 must be completed

Part 1 To Grant Consent

In the event reasonable attempts to contact me at _____ (phone #) or _____ (other parent or guardian) at _____ (phone #) have been unsuccessful, I here by give my consent and accept financial responsibility for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) Phone # _____ or Dr. _____ (preferred dentist) Phone # _____ or in the event the designated preferred practitioner is not available, by another licensed physician or dentist: and (2) the transfer of the child to _____ (preferred hospital) or any hospital reasonably accessible. This authorization does not cover major surgery, unless the medical opinions of surgeons are obtained prior to the performance of such surgery. Facts concerning this child's medical history, including allergies, medications being taken and any physical impairments to which a physician should be alerted:

Date: _____ Signature of Parent or Guardian _____
Address: _____

Part 2 Refusal to Consent

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the Bloom-Carroll Youth Athletics to take no action or to:

Date: _____
Signature of Parent or Guardian: _____
Address: _____

Note: Signing Refusal of Consent will require a parent or legal guardian at all events. In any event, BCYA will activate 9-1-1 to contact local Emergency Medical Services