

St. Cloud Travel Baseball

Registration Form

Player's Name: _____

Currently attending what school: _____

Date of Birth: ____/____/____ Age as of **April 30, 2010** _____

Grade Level in 2009-2010 School Year: _____

Parents/Guardians Names: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: () _____ Cell: () _____

Work Number: () _____ E-Mail: _____

Emergency Contact: _____

Emergency Contact Phone Number: () _____

Physician's Name: _____ Phone: () _____

Physician's Address: _____

Any medical condition or medication coaches should be aware of:

I the parent/guardian of the registrant, a minor, hereby agree that I and registrant will abide by the rules of St. Cloud Travel Baseball and its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with baseball, and in consideration for St. Cloud Travel Baseball accepting the registrant for its baseball programs and activities, I hereby release, discharge and/or otherwise indemnify St. Cloud Travel Baseball, its affiliated organizations and sponsors, their volunteers and/or associated personnel, including the owners of the fields and facilities utilized by the Association, against any claim by or on behalf of the registrant as a result of the registrant's participation in the programs offered by the Association and/or being transported to or from the same, which transportation I hereby authorize.

Medical insurance is the responsibility of each player and his or her parent or guardian.

Parent/Guardian Signature: _____ Date: _____