2024 Seneca East Summer Softball

Players Name:	Birth Date:
Address:	Age as of August 1, 2023
City	Zip
Mother's Name:	Phone: □home □cell □cell & texting
Father's Name:	Phone: □home □cell □cell & texting

I waive all claims for injury, accident, or liability of any kind against the Seneca East Summer Softball League, including their officers, coaches, sponsors, or other players.

Signature of parent/guardian: _____Date: _____

REGISTRATION DEADLINE: Friday, FEBRUARY 16th, 2024.

PLEASE turn form and payment in an envelope **(NO STAPLES)** to the elementary or high school office.

Late entry forms will NOT be accepted after February 23, 2024

Registration Fee: $40 per girl with a maximum of $75 per family.

Please make checks payable to: Seneca East Summer Softball

Are you interested in coaching? □yes □no

Current grade level_____ Position (s)_____

Shirt size: YS YM YL AS AM AL AXL (please circle one)

Please select two numbers for your shirt: 1st choice _____ 2nd choice _____

*****please note that your child will be required to participate in any fundraising that our league participates in.*****

*****PLEASE COMPLETE AND SIGN THE HEALTH AND MEDICAL RECORD ON REVERSE SIDE*****

Health and Medical Record

Player's Name_____Birth Date_____

I/We know that participation in softball may result in serious injuries and protective equipment does not prevent all injuries to players, and I/we do hereby waive, release, absolve, indemnify, and agree to hold harmless the Seneca East Summer Softball League, the organizers, sponsors, coaches, supervisors, participants, and persons transporting my/our child to and from activities.

Parent's signature_____Date_____

Health/Accident

Insurance Company_____Policy #_____

In case of an emergency, notify:

Name_____Relationship_____

Address_____City_____Zip_____

Home Phone_____Other Phone_____

Personal Physician_____Phone_____

The player on this form has or is subject to:

___Allergy to medicine, food, plant, animal, or insect toxin

___Asthma ___Bleeding Disorder ___Convulsions

___Diabetic ___Fainting Spells ___Heart Trouble

___Other_____

Please explain below any that have been checked or any other pertinent medical information:

_____

_____

_____

Parent Authorization:

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by another physician who is available.

Parent signature_____Date_____