

Collinsville Softball Association

2010 Softball Registration

Age Group:  6U  8U  10U  12U  14U

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Alt Telephone: \_\_\_\_\_

Email: \_\_\_\_\_ Alt Email: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age as of January 1, 2010 \_\_\_\_\_

Years Played: \_\_\_\_\_ Favorite Position(s): \_\_\_\_\_

Shorts Size: YS YM YL YXL AS AM AL AXL Select Player: Yes No

Jersey Size: YS YM YL YXL AS AM AL AXL

Parent or Guardian: \_\_\_\_\_ Telephone: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Telephone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Special Medical Concerns / Special Needs: \_\_\_\_\_

I am interested in helping with:  Coaching (Must complete Coaches Application),  Assistant Coaching (Must complete Coaches Application),  Umpiring,  Other (Specify): \_\_\_\_\_

IMPORTANT - PLEASE READ AND SIGN BELOW

I, the parent/guardian of the registrant, a minor, agree that registrant and I will abide by the rules of the Baseball and Softball Association (CBSA) and any organizations that are affiliated with the CBSA. I recognize that there are possibilities of physical injury associated with playing and practicing this or any sport, and in consideration of the CBSA accepting the registration for its sports programs and activities (the "Programs"), I hereby release, discharge, and/or otherwise indemnify the CBSA, its affiliated organizations, their employees and associated personnel, including the board of directors of this organization and affiliated organizations, the coaches, the owners/operators of the fields and facilities and their employees utilized for the Programs, against all claims by or on behalf of the registrant as a result of the registrant's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize.

As the parent or legal guardian of the above-named player, I hereby 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.

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

REFUND POLICY - Registrations are 100% refundable until uniforms are ordered. No refunds will be allowed after that date.

Payment Type: Cash \_\_\_\_\_ Check \_\_\_\_\_ Scholarship \_\_\_\_\_

PAYMENT-85.00

Approval by: \_\_\_\_\_