



# TROY JUNIOR BASEBALL INC.

--	--	--

Player Name:		Preferred Phone:	Cell / Home
Address:			
Age as of May 1:	Birthdate (Month and year required as a minimum):	mm / dd / yy	Sex:
School:			Grade:

- I do not want my child's name and/or photo to appear on the TJB Website
- TJB may use the provided contact info for other than direct TJB matters, i.e. political, etc.

**PLAYER UNIFORMS** – Circle Youth or Adult and Size for each item.

SHIRT	HAT
Youth / Adult	Youth / Adult
Sm / Med / Lg / XL	

Did player play with TJB last year? <b>Yes</b> or <b>No</b>	What League? T-ball / J-Ball / Minors / Majors / Teener
What Team?	
Has the player ever played ( <i>in Minors, Majors or Teener</i> ):	Pitcher? <b>Yes</b> or <b>No</b> Catcher? <b>Yes</b> or <b>No</b>

**PARENT OR GUARDIAN CONTACT INFO** (Please list Residential parent first)

Name:	Relationship:
Email Address:	Preferred Phone:      Cell / Home
	Phone#2:      Cell / Home / Work
Name:	Relationship:
Email Address:	Preferred Phone:      Cell / Home
	Phone#2:      Cell / Home / Work
Name:	Relationship:
Email Address:	Preferred Phone:      Cell / Home
	Phone#2:      Cell / Home / Work
Emergency Contact:	Relationship:
Home Address:	Preferred Phone:      Cell / Home

**< == OVER == >**

**No Refunds after Sept 1st**

<b>For Office Use Only</b>	League T-ball / J-Ball / Minors / Majors / Teener / FALL BALL
Amount Paid:	Cash or Check # _____ Date Paid:

**EMERGENCY MEDICAL AUTHORIZATION**

**Player's Name:** \_\_\_\_\_

Allergies:	The coach should also know:
------------	-----------------------------

The above player is **COVERED / NOT COVERED** (circle one) by private / public medical insurance in case of injury. I understand that injury may occur due to the physical nature of baseball. I also release Troy Junior Baseball (TJB) of any financial responsibility in the event an injury should occur.

**Parent / Guardian Signature:**

**Date:**

***PURPOSE** – To enable parents/guardians to authorize the provision of emergency treatment for children that become ill or are injured while participating in the TJB program, when parents/guardians cannot be reached.*

**To GRANT Consent**

Primary Care Physician:

Phone:

Dentist:

Phone:

Medical Specialist:

Phone:

Hospital:

Phone:

In the event reasonable attempts have been made to contact me have been unsuccessful. I hereby give me consent for the administration of any treatment deemed necessary by the above named doctors / facilities, or in the event the designated preferred doctor facility is not available, by another doctor/facility and the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless medical opinions of the two other licensed physicians/dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medication being taken, and any other physical impairment should be alerted.

**Parent / Guardian Signature:**

**Date:**

**To REFUSE Consent**

I **DO NOT** give consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the authorities to take the following action(s):

**Parent / Guardian Signature:**

**Date:**