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ATTENTION 5TH AND 6TH

GRADE GIRLS!!

LADY CAVALIERS

ARE READY TO PLAY

If you are interested in playing

Lady Cavalier Basketball,

Please contact Amy Straub at

814-594-0681 or

apstraub@windstream.net

Complete forms and submit the

Registration fee

By August 10th



5th / 6th Grade Lady Cavaliers Basketball



Application Form:

Athletes Name: _____

Grade: _____

School: _____

Age: _____

Birth Date: _____

Fee: \$25.00 per child; \$40.00 per family. Please make checks payable to: **Lady Cavaliers Basketball**

I / We the parents of the above named candidate for a position in the Lady Cavaliers Basketball Program, hereby give my/our approval to participate in any and all Lady Cavalier activities.

I/We understand that participation in basketball may result in serious injuries and do hereby waive, release, absolve, indemnify, and agree to hold harmless the Lady Cavalier Basketball program, the organizers, sponsors, supervisors, and participants for any claims arising out of any injury to my/our child whether the result of negligence or for any other cause, except to the extent and in the amount covered by accident or liability insurance.

Parent / Guardian: _____

Name (Please print)

Signature

Date: _____

Email address: _____

Paid: Check# _____

Cash: _____

Child's shirt size: _____

LADY CAVALIER BASKETBALL

Emergency Medical Form

Athlete's Name: _____

Grade: _____ School: _____

Age: _____ Birth Date: _____

In Case of Emergency, please notify:

Name

Relationship

Phone

Name

Relationship

Phone

Parent / Guardian Signature:

I/We consent to any necessary examination, anesthetic, medical diagnosis or treatment and/or hospital care to be rendered to the above named minor child.

Date: _____ **Signed:** _____

Address: _____

City: _____ **Home Phone:** _____

Cell Phone: _____ **Email Address:** _____

Health Insurance Information (note: this information MUST be on file with the Athletic Director/Coach(es) before participation in games or practices will be permitted):

Carrier: _____ **ID#:** _____

Group Number: _____ **Hospital:** _____

Family Physician: _____ **Surgeon:** _____

Pediatrician: _____ **Drugstore:** _____

Medications: _____

Allergies: _____

Medical Conditions: _____
