

Granite State Marauders

Registration Form

Player Name: _____ **Phone:** _____ **Birth Date:** _____
Address: _____ **City:** _____ **State/Prov.** _____
Gender Male Female **Height** _____ **Weight** _____ **Postal Code** _____

Email Address: _____

Guardian Name: _____ **Phone:** _____ **Relationship:** _____
Guardian Name: _____ **Phone:** _____ **Relationship:** _____
Emergency Contact: _____ **Phone:** _____ **Relationship:** _____
School Name: _____ **Grade:** _____

Division Preference	Min Age	Max Age	Shirt Size	Pants Size
<input type="checkbox"/> 11U	9	11	<input type="checkbox"/> Y-S	<input type="checkbox"/> Y-S
<input type="checkbox"/> 12U	10	12	<input type="checkbox"/> Y-M	<input type="checkbox"/> Y-M
<input type="checkbox"/> 13U	11	13	<input type="checkbox"/> Y-L	<input type="checkbox"/> Y-L
<input type="checkbox"/> 14U	12	14	<input type="checkbox"/> Y-XL	<input type="checkbox"/> Y-XL
<input type="checkbox"/> 15U	13	15	<input type="checkbox"/> A-S	<input type="checkbox"/> A-S
<input type="checkbox"/> 16U	13	16	<input type="checkbox"/> A-M	<input type="checkbox"/> A-M
			<input type="checkbox"/> A-L	<input type="checkbox"/> A-L
			<input type="checkbox"/> A-XL	<input type="checkbox"/> A-XL
			<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Hat Size: _____

Shoe Size: _____

League Use Only

Date Paid: _____

Cash Online
 Check

Chk Nbr: _____

Player Fee: _____

Other Fees: _____

Total Paid: _____

Medical Information

Preferred Doctor Name: _____ **Phone:** _____
Preferred Dentist Name: _____ **Phone:** _____
Preferred Hospital: _____
Insurance Carrier: _____ **Policy Number:** _____

Medical History: Allergies, Medications, Special Conditions, etc

Medical Authorization

PART I GRANT OF CONSENT

In the event reasonable attempts to contact the parents or guardians have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by preferred Dr.(2), or preferred Dentists or in the event designated Dr. or Dentist is not available, by another licensed physician or dentist; and (2) the transfer of the child to preferred hospital or any hospital reasonably accessible.

NOTE: This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring in necessity for such surgery are obtained BEFORE the surgery IS PERFORMED.

Participant Name: _____
Print Name

Parent/Guardian/Custodian: _____ **Date:** _____
Signature

PART II REFUSAL OF CONSENT (Do not complete if Part I has been completed)

I do NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish that Granite State Marauders to take no action, or perform the following actions:

Actions to be Performed: _____

Participant Name: _____
Print Name

Parent/Guardian/Custodian: _____ **Date:** _____
Signature