

South Mission Viejo Little League Fall Ball Application

Team	Fee is \$75.00
Division	League Age

age as of 4/30/2012

Player's Name (Last, First, Middle)			Street Address		
City	State	Zip	Home Phone	E-Mail Address	
Father's Name (Last, First)		Home Phone	Work Phone	Cell Phone/Pager #	
Mother's Name (Last, First)		Home Phone	Work Phone	Cell Phone/Pager #	
Birthdate	Age	Sex	School		
Returning Player?	Last Season's Division	Last Season's Team	Shirt Size: YM YL AS AM AL AXL XXL		
What position did you play last year?			What position do you want to work on during the Fall Season?		
Do you have any requests?					

PARENT'S PERMISSION AND EMERGENCY MEDICAL RELEASE SIGNATURE

I/We, the parent(s) or guardian of the above-named child, hereby give my/our approval to this participation in any and all of the activities of Little League Baseball during the current season. I/We assume all risks and all hazards incidental to the conduct of the activities and transportation to and from the activities. I/We do further hereby release, absolve, indemnify and hold harmless Little League Baseball, Inc., the organizers, sponsors, directors, and supervisors, any or all of them. In the case of injury to my/our child, I/we do hereby waive all claims against the organizers, the sponsors, directors and any and all of the supervisors appointed by them. I/We likewise waive, to the extent not covered by liability insurance, any claim against any transporting of my/our child to or from the activities.

I/We, the undersigned parents or legal guardian of the above stated minor, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any members of the medical staff and emergency room staff licensed under the Medical Practice Act, or a dentist licensed under the Dental Practice Act and on the staff of any general hospital, holding a current license to operate a hospital from the State of California, Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care which above-mentioned physician, in the exercise of his/her treatments will not be withheld if the undersigned cannot be reached. A copy of this release may be used in lieu of the original

Parent(s) or Legal Guardian(s): _____ Date: _____
(Please Print)

Signature of Parent or Guardian: _____ Date: _____

Allergies or Other Information Relating to Player's Health	
Emergency Contact:	Phone Number
Physician's Name:	Phone Number
Comments:	

checks payable to:

South Mission Viejo Little League

mail to: **Hallie Hannah**

14 Ashton

Mission Viejo , CA 92692

halliehannah@cox.net

