

G.Y.A.A Spring Sports

Circle One:

Lacrosse (5th & 6th graders only)

T-Ball (5-7 yr olds) **Rookie** (7-9 yr olds) **Minors** (8-12 yr olds)

Majors (10-12 yrs olds) ****Note:** All 10-12 yr olds who don't make Majors will play Minors.

Babe Ruth (13-16 yr olds) ****Note:** Tryouts, fee due upon selection to team.

All Females: U. ASA-JO Softball (10 & under) **U. ASA-JO Softball** (12 & under)

U. ASA-JO Softball (14 & under) ****Note:** Register only – TBA

Child's Name: _____ **Date of Birth:** ____/____/____

School & Grade: _____ **Age Now:** _____

I, the parent or guardian of the child named above, hereby give my consent to his/her participation in all activities of the Greene Youth Athletic Association, and release from responsibility it's organizers, sponsors, coaches and others acting under the direction of the G.Y.A.A.. I also release from responsibility any person transporting my child to or from the activities.

I also agree to furnish a copy of my child's birth certificate upon request (for tournaments).

Parent/Guardian Signature: _____

Home Phone: _____

I or my spouse is interested in assisting with a sport: **YES** or **NO**

If yes, state his/her name and what program: _____

What level did your child participate in last year? _____

Which G.Y.A.A. team? _____

There are some scholarships available, call director of child's sport or check box and we will
 call you.

Fill out Backside, please!!

Please make checks payable to (G.Y.A.A. or Greene Youth Athletic Association)

***** **DO NOT WRITE BELOW THIS LINE** *****

Amount: _____ Cash: _____ Check#: _____ Accepted by: _____

**CONSENT TO TREAT
GREENE YOUTH ATHLETIC ASSOCIATION**

I, _____, do hereby grant my consent and authorization for my child _____ to receive emergency medical treatment in accordance with the details described below in the event that I cannot be reached.

Preferred Hospital: _____

Family Physician: _____ **Telephone#:** _____

Known Allergies/Medical Problems: _____

Last Tetanus Shot: _____

Insurance Carrier: _____ **Policy#:** _____

Parent/Guardian Signature: _____

Home Address: _____

Relationship: _____ **Date:** ___/___/___ **Witness:** _____

Do not fill out this portion below unless the child has no insurance.

I do not have medical insurance for my child. I hereby grant my authorization for emergency medical treatment to be obtained for my child _____, and I acknowledge and accept that I am responsible for payment of any bill resulting from said treatment and shall not hold the coach or the Greene Youth Athletic Association responsible.

Parent/Guardian Signature: _____

Relationship: _____ **Date:** ___/___/___ **Witness:** _____