SUMMER CLINIC REGISTRATION

WWW.SOUTHBBALL.COM

Player(s) Information

Full Name: **Grade:** **School:** **Shirt Size:**

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Parent/Guardian Information

Full Name: **Address:**

Home Phone: **Cell Phone:**

Please Write Clearly

EMAIL(S):

(Please provide multiple email addresses if there is more than one Parent/Guardian that wants to be informed of important SPYB Announcements, this will be a main form of communication as well as the website www.southbball.com ***also if you have a Gmail email, our emails sometimes go to "Promotional" part of the inbox on gmail & on other email platforms like yahoo, please make sure to check your junkmail/spam box, to ensure you don't miss any emails)***

Emergency Contact

Full Name: **Phone:**

Relationship:

Emergency Medical Treatment Release

I/We_____the parents of the above named registrant(s) do herby grant my/our permission for my/our son(s) or daughter(s) to participate in all activities of South Plymouth Youth Basketball. I/We do know that participation in basketball may result in serious injury and protective equipment does not prevent injuries to all players. I/We do herewith authorize treatment under the direction of any licensed physician, for the above named minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after reasonable effort has been made to reach me by phone at the number listed above. The undersigned assumes the responsibility for any cost connected with such treatment and does hereby release, waive, absolve, indemnify and agree to hold harmless the SPYB, it's directors, sponsors, organizers, participants and persons transporting my/our child whether the result of negligence or for any other cause, except to the extent of and in the amount of covered by liability insurance from any liability thereof. This release form is completed and signed of my own free will with the purpose of authorizing medical treatment under emergency circumstances in my absence

SIGNATURE OF PARENT OR GUARDIAN:

DATE:

CHECKS PAYABLE TO: "SPYB" **COST PER PLAYER $250.00**

SPYB USE ONLY

CASH AMOUNT REC'D: CHECK AMOUNT REC'D CHECK #