



# ALABASTER GIRL'S SOFTBALL

# 2019 Spring Registration Form

**Registration Fee: \$165.00**

**NO Checks Accepted**

*Non-Resident Fee: Additional 10%*

*We accept Cash, Debit, Visa, MasterCard*

**4.5% service fee for debit/credit card payments**

*Multi Child Discount: 10%*

**Would either parent be interested in coaching?**

**Team MOM**

**HEAD Coach – DAD**

**ASSISTANT Coach – DAD**

**HEAD Coach – MOM**

**ASSISTANT Coach – MOM**

**Child's Name:** \_\_\_\_\_  
FIRST MIDDLE LAST

**Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Division: (check one)**

**6U** (Coach Pitch - age 5/6)

**8U** (Coach /Player Pitch - age 7/8)

**10U** (Player Pitch - age 9/10)

**12U** (Player Pitch - age 11/12)

**Mother's Name:** \_\_\_\_\_ **Cell No.:** \_\_\_\_\_ **Work No.:** \_\_\_\_\_

**Primary EMAIL Address:** \_\_\_\_\_  
*Please print LEGIBLY!*

**Father's Name:** \_\_\_\_\_ **Cell No.:** \_\_\_\_\_ **Work No.:** \_\_\_\_\_

**Primary EMAIL Address:** \_\_\_\_\_  
*Please print LEGIBLY!*

**Address:** \_\_\_\_\_  
Mailing Address City State Zip

**Primary Phone:** \_\_\_\_\_

In Case of an **Emergency**, if parents cannot be reached, please contact:

**Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

Please list any **ALLERGIES/MEDICAL PROBLEMS**, including those requiring maintenance medications (i.e. diabetic, asthma, seizure disorder). Include medical diagnosis, medication, dosage, and frequency of dosage.

**TREATMENT AUTHORIZATION:**

In case of an emergency, if I, or the family physician, cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, ER Physician).

Name of Pediatrician or Family Physician: \_\_\_\_\_

\_\_\_\_\_

**INITIALS**

Phone: \_\_\_\_\_

**NEW** or  **RETURNING** Softball Player

Where do you attend **School?** \_\_\_\_\_

Softball **Experience** (seasons played) \_\_\_\_\_

**Current Grade** \_\_\_\_\_

**Birth Certificate** is:  Attached  Not Attached  On-file

**Age as of Jan. 1, 2019** \_\_\_\_\_

**YES** or  **NO**

Softball Player will be attending the **Player's Clinic** on Feb. 4 & 5 from 5:30 PM until 7:30 PM at the NEW Thompson High School Softball Field. The \$35 fee needs to be paid at the clinic – Cash Only. NOTE: The clinic is not mandatory.



**You're not finished until you complete Page 2**

Player's Name: \_\_\_\_\_

**Refunds:** I/We, the parent(s)/guardian(s) of the above named child, understand that refunds are not guaranteed. They will be considered depending on the circumstances. If approved, the refund amount will be determined after deducting the cost of any items already ordered for the participant.

\_\_\_\_\_

**INITIALS**

Per **Alabaster City Ordinance 95-381** I understand: *Any person who engages in arguments, uses abusive language, harasses game or league officials or exhibits any unsportsmanlike behavior, may be barred from parks and/or recreation facilities and/or prosecuted.*

\_\_\_\_\_

**INITIALS**

**Observations:** I will refer to the "Important Dates" document for Observation dates and times, and have my child present at their designated time; or email Morgan Lawley at [mnlawley@cityofalabaster.com](mailto:mnlawley@cityofalabaster.com) if unable to attend. *Failure to attend will affect how the player is drafted. The player's name will be drawn from a hat.*

\_\_\_\_\_

**INITIALS**

**MEDICAL AUTHORIZATION/CLAIM & REIMBURSEMENT DISCLAIMER:**

I/we, the parent(s) and/or legal guardian(s) of the above named candidate, know that participation in Alabaster Youth Sports may result in serious injury(ies), and moreover protective equipment does not prevent all injuries to participants. Therefore I do in consideration of being allowed to participate in the above named activity, hereby assume all responsibility for said activity and/or child. I authorize the City of Alabaster Parks and Recreation Department (CAPRD) to obtain necessary medical care and treatment for the participant for any illness or injury occurring during the activity period, but I understand CAPRD is NOT assuming a duty to obtain medical treatment, make medical decisions, or render medical care or treatment to the participant. I understand that CAPRD has NO ACCIDENT or MEDICAL PAYMENT INSURANCE COVERAGE for the participant and I agree to pay all reasonable medical costs incurred if treatment is obtained. I release, indemnify and agree to hold harmless, CAPRD and its agents, elected officials, servants, and employees from all claims, action, causes of action and rights of recovery or reimbursements of any type that any participant has or may have in the future which arise from or are related in any manner to the activity(ies) (including, but not limited to, claims of bodily injury and property damage or loss), and I assume all risks and hazards incident to such activity(ies) and transportation to and from the same. This instrument is signed both individually and on behalf of the participant(s) present at activity(ies).

\_\_\_\_\_

**INITIALS**

**PARENTAL AUTHORIZATION:**

I hereby give my approval for the above named child to participate in all Softball activities during the current season. I am the parent or legal guardian of the child that I have registered. I certify that all information given is correct.

\_\_\_\_\_  
**Authorized Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

**NOW you are finished! Thanks!**



**FOR OFFICE USE ONLY**

**Amount Paid** \_\_\_\_\_

Cash     Discover     Master Card     Visa     Debit

**Receipt No. OR Last 4 digits of Charge Card** \_\_\_\_\_

**Authorization Code** \_\_\_\_\_

**Date Paid** \_\_\_\_\_

**Employee initials** \_\_\_\_\_