

# Granite State Marauders

## Registration Form

Player Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Prov. \_\_\_\_\_  
 Gender  Male  Female Height \_\_\_\_\_ Weight \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Parent Approval to Contact Participant via Email (for children under the age of 13)  Yes  No  
 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"/> 12U	10	12		
<input type="checkbox"/> 13U	11	13		
<input type="checkbox"/> 14U	12	14		
		<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____

Hat Size: \_\_\_\_\_  
 Shoe Size: \_\_\_\_\_  
 Jersey Number Preference: \_\_\_\_\_

League Use Only

Date Paid: \_\_\_/\_\_\_/\_\_\_

Cash  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