



P.O. Box 233 Bulverde, TX 78163

BulverdeLittleLeague.org

President: Steve Yosko

If Player Does Not Tryout They Are Not Eligible For All-Stars
In order to be eligible for All-Stars you must provide
proof of residency dated before February 1, 2012

GIRLS FAST-PITCH SOFTBALL

PLAYER'S AGE ON
DECEMBER 31,
2011

BASEBALL

PLAYER'S AGE ON
APRIL 30TH,
2012

(BIRTH CERTIFICATE REQUIRED)

Verified by: _____

T-Ball

Machine Pitch

Minor (girls)

Minor (boys)

Major (girls)

Major (boys)

Junior (girls)

Junior (boys)

Senior (girls)

Senior (boys)

Big League

REGISTRATION _____

DONATION _____

ADDITIONAL
REGISTRATIONS _____

TOTAL _____

CASH

CHECK # _____

RECEIVED BY: _____

DO NOT WRITE IN THIS BOX - LEAGUE USE ONLY

REQUIRES TRYOUTS

PLAYER INFORMATION

M/F	DATE OF BIRTH		MM/DD/YYYY
NAME	FIRST	MIDDLE	LAST
ADDRESS	_____		
	CITY	STATE	ZIP
PHONE	CELL		
SCHOOL	SEASON LAST PLAYED		
PREVIOUS LEAGUE	PREVIOUS DIVISION		

MEDICAL INFORMATION

DOCTOR NAME	PHONE
ANY ALLERGIES OR MEDICAL RESTRICTIONS?	
EMERGENCY CONTACT	PHONE

PARENT INFORMATION

MOTHER	NAME	HOME
	OCCUPATION	WORK
	EMAIL	CELL
FATHER	NAME	HOME
	OCCUPATION	WORK
	EMAIL	CELL

VOLUNTEER INFORMATION

UMPIRE <input type="checkbox"/>	MANAGER <input type="checkbox"/>	COACH <input type="checkbox"/>
SCOREKEEPER <input type="checkbox"/>	TEAM PARENT <input type="checkbox"/>	

SPONSOR INFORMATION

YES I would like to be a sponsor

Please Contact Me _____ Phone _____

PLAYER'S SHIRT SIZE

Youth: Small Med Large X-Large
Adult: Small Med Large X-Large

ADDITIONAL CHILDREN FROM
HOUSEHOLD REGISTERING IN
BULVERDE LITTLE LEAGUE

NAME	D.O.B.
NAME	D.O.B.
NAME	D.O.B.

I, the parent/guardian of the registrant, a minor, agree that I and the registrant will abide by the rules of the Bulverde Little League, its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with baseball and in consideration for the Bulverde Little League, accepting the registrant for its baseball programs and activities ("the programs"), I hereby release, discharge and/or otherwise indemnify the Bulverde Little League, its affiliated organizations and sponsors, their employees and associated personnel, including the owners of the fields and facilities utilized for the Programs, against any claim by or on behalf of the registrant as a result of the registrant's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize.

As the parent or legal guardian of the above-named player, I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.

NAME _____	SIGNATURE _____
ADDRESS _____	CITY _____ STATE _____ ZIP _____
PHONE _____	DATE _____



Little League. Baseball and Softball M E D I C A L R E L E A S E



NOTE: To be carried by any Regular Season or Tournament Team Manager together with team roster or eligibility affidavit.

Player: _____ Date of Birth: _____ Gender (M/F): _____

Parent (s)/Guardian Name: _____ Relationship: _____

Parent (s)/Guardian Name: _____ Relationship: _____

Player's Address: _____ City: _____ State/Country: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

PARENT OR GUARDIAN AUTHORIZATION:

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

Family Physician: _____ Phone: _____

Address: _____ City: _____ State/Country: _____

Hospital Preference: _____

Parent Insurance Co: _____ Policy No.: _____ Group ID#: _____

League Insurance Co: _____ Policy No.: _____ League/Group ID#: _____

If parent(s)/guardian cannot be reached in case of emergency, contact:

Name	Phone	Relationship to Player

Name	Phone	Relationship to Player

Please list any allergies/medical problems, including those requiring maintenance medication. (i.e. Diabetic, Asthma, Seizure Disorder)

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

Date of last Tetanus Toxoid Booster: _____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Mr./Mrs./Ms. _____
Authorized Parent/Guardian Signature Date: _____

FOR LEAGUE USE ONLY:

League Name: _____ League ID: _____

Division: _____ Team: _____ Date: _____