



HAMPTON TORNADOS



YOUTH FOOTBALL AND CHEERLEADER LEAGUE REGISTRATION FORM

Child's Name: _____
(Last) (First) (MI)

Child's D.O.B.: _____ Birth Certificate in File w/ Tornados: _____
(YES)

Age on 7/31/17: _____

Parent or Legal Guardian's Name: _____

Address: _____
(Apt # or Street Address) (City) (Zip)

Phone Number: _____
() (Home) () (Work/Cell)

EMERGENCY CONTACT INFORMATION
(Person to be contacted if you are unreachable)

Name: _____ Contact Number: _____
()

Address: _____ Relationship: _____

My child may participate in all Hampton Tornados Organizational activities:

Parent/Guardian's Signature Date

(Step and complete reverse side of this form)

ORGANIZATIONAL INFORMATION

Registration Fees Paid: _____
(Date) (Amount) (Receipt No.)

Uniform Rental Fee Paid (if applicable): _____
(Date) (Date of Receipt No.)

Date Uniform Issued: _____ Jersey No: _____ Size: _____

Date Uniform Returned: _____



PLEASE NOTE: REGISTRATION FEE IS NON-REFUNDABLE AND THERE WILL BE A \$25 CHARGE FOR RETURNED/NON-SUFFICIENT CHECKS



MEDICAL TREATMENT PERMISSION FORM

In the event of an emergency occurring while my son/daughter is on a recreation sponsored practice, performance or trip, I grant permission to the recreational facility and its staff to take whatever action necessary. In the event that I cannot be reached, I hereby authorize the recreational facility and/or its employees to give consent for my son/daughter,

_____ to receive medical treatment _____
(Child's Name) (Parent/Guardian's Signature)

Persons to be notified other than parent or guardian in an emergency:

Name: _____ Contact Number: _____

Child Physician: _____ Contact Number: _____

If you DO NOT grant permission or authorization for consent to medical treatment, what procedure should be followed?

Insurance Company: _____ Policy No: _____

Parent/Guardian's Signature

Date

ACKNOWLEDGEMENT OF RISK AND INSURANCE STATEMENT
(to be completed and signed by parent/guardian)

I give permission for _____ (name of child/ward) to participate in any of the following sports that are not crossed out: baseball, basketball, cheerleading, cross country, field hockey, football, golf, gymnastics, lacrosse, soccer, softball, swimming/diving, tennis, track, volleyball, wrestling, other (identify sport(s)).

I have reviewed the individual eligibility rules and I am aware that with the participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk varies significantly from one sport to another with contact sports carrying the higher risk. I have had an opportunity to understand the risk inherent in sports through meetings, written handouts, or some other means.

~~He/She~~ has student accident insurance available: Yes _____ No _____ is insured by our family policy with:

Name of Company: _____

Policy Number: _____ Name of Policy Holder: _____

I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for _____ (child/ward) to participate in the sport and travel with the team.

Additionally, I give my consent and approval for the above named student's picture and name to be printed in any _____ athletic program, publication or video.

EMERGENCY PERMISSION FORM
(to be completed and signed by parent/guardian)

Student's Name: _____ Grade: _____ Age: _____

School: _____ City: _____

Please list any significant health problems that might be significant to a physician evaluating your child in case of an emergency _____

Please list any allergies to medications, etc. _____

Has student been prescribed an inhaler or **EpiPen**? _____

Is student presently taking medication? _____ If so, what type? _____

Does student wear contact lenses? _____ Please list date of last tetanus shot _____

EMERGENCY AUTHORIZATION

In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches and staff of _____ (team) to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the person named above.

Daytime phone number (where to reach you in an emergency) _____

Evening time phone number (where to reach you in an emergency) _____

Parent/Guardian's Signature _____ Date: _____

Relationship to Student: _____

* *Emergency Permission Form may be reproduced to travel with respective teams and is acceptable for emergency treatment if needed.*

I certify all the above information is correct _____

Parent/Guardian's Signature

MEDICAL HISTORY

This form must be completed by parent/guardian prior to the physical examination and should be taken with the physical examination form for review by the physician during the examination.

YES

NO

1. Have you ever had any of the following? *Please explain any YES answers.*
Heart murmur? _____
High blood pressure? _____
Other heart problems? _____
Broken bones? _____
Weak joints - ankles, knees? _____
Concussion? _____
Operation? _____
Seizures or epilepsy? _____
2. Have you ever fainted or passed out? _____
3. Have you ever been knocked out? _____
4. Have you ever been hospitalized? _____
5. Have you ever had to stop running after ¼ or ½ miles for chest pain or shortness of breath?

6. A. Have you ever had significant allergies to?
Bee stings? _____ On medication? _____ Yes _____ No _____
Foods? _____
Medicines? _____
Others? _____
B. Do you have a prescription for use of?
Adrenaline? _____
Inhalers? _____
Other allergy medicine? _____
C. Do you have asthma? _____
7. Do you take any medicine regularly? _____
8. Have you had any illnesses lasting a week or more such as mononucleosis, etc?

9. Have you had any blood disorders, including sickle cell trait, anemia, etc.? _____
10. Has any family member had a heart attack, heart problems or sudden death before the age of 50? _____
11. Do you wear contact lenses, eyeglasses or dental appliances? _____
12. Do you have any missing or non-functioning organs such as testes, eye, kidney, etc?

13. Do you have any other significant health problems? _____
14. Hepatitis B Immunization Series? _____
15. Date of last Tetanus Immunization? _____

Parent/Guardian's Signature _____

Date: _____



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LEAGUE REGISTRATION FORM**



Child's Name: _____
(Last) (First) (M.I)

Child's D.O.B.: _____ Birth Certificate on File w/Tornados: _____
(Y/N)

Age as of September 1, 2017: _____

Parent or Legal Guardian's Name: _____

Address: _____
(Apt.# or Street Address) (City) (Zip)

Phone Number: () _____ () _____
(Home) (Work/Cell)

EMERGENCY CONTACT INFORMATION
(Person to be contacted if you are unreachable)

Name: _____ Contact Number: () _____

Address: _____ Relationship: _____

My child may participate in all Hampton Tornados Organizational activities:

Parent/Guardian's Signature *Date*

(Stop and complete reverse side of this form)

ORGANIZATIONAL INFORMATION

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_____ to receive medical treatment. _____

Child's Name

Parent/Guardian's Signature

Person to be notified other than parent or guardian in an emergency:

Name: _____ Contact Number: () _____

Child's Physician: _____ Contact Number: () _____

If you DO NOT grant permission or authorization for consent to medical treatment, what procedure should be followed?

Insurance Company: _____ Policy No: _____

Parent/Guardian's Signature

Date

MEDICAL INFORMATION

- | | <u>YES</u> | <u>NO</u> |
|---|------------|-----------|
| 1. Heart Condition or disease? | _____ | _____ |
| 2. Diabetes? | _____ | _____ |
| 3. Convulsions disorder? | _____ | _____ |
| 4. Asthma? | _____ | _____ |
| 5. Allergic to medication (if so state below) | _____ | _____ |
| 6. Allergic to insect bites/stings? | _____ | _____ |
| 7. Date of last Tetanus Immunization? | | |

8. Additional information that may be helpful

9. List current medication(s) taking

