

Check Number: \_\_\_\_\_

Amount: \_\_\_\_\_

# Our Lady of Hope CYO Basketball 2007 Registration Form Grades K -3

Registration Fee: \$35.00 per child (include shirt)  
\$30.00 per returning child who already has a shirt

Make checks payable to Our Lady of Hope, CYO

## Player Information

Family Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mother Cell Phone: \_\_\_\_\_ Father Cell Phone: \_\_\_\_\_

1<sup>st</sup> E-mail: \_\_\_\_\_ 2<sup>nd</sup> E-mail: \_\_\_\_\_

Players Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M/F \_\_\_\_\_ Grade: \_\_\_\_\_

Players Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M/F \_\_\_\_\_ Grade: \_\_\_\_\_

Players Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M/F \_\_\_\_\_ Grade: \_\_\_\_\_

Name of School: \_\_\_\_\_

Shirt Sizes (if applicable): YS \_\_\_\_\_ YM \_\_\_\_\_ YL \_\_\_\_\_ XL \_\_\_\_\_

AS \_\_\_\_\_ AM \_\_\_\_\_ AL \_\_\_\_\_ AXL \_\_\_\_\_

Is player participating in any other basketball or sports programs which may conflict with commitment to this program? Y / N --- \_describe\_\_\_\_\_

Please indicate if you can volunteer as: Head Coordinator                      Coach

Medical Information:

Name: \_\_\_\_\_ Allergy: \_\_\_\_\_

Name: \_\_\_\_\_ Allergy: \_\_\_\_\_

Name: \_\_\_\_\_ Allergy: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Our Lady of Hope  
CYO Basketball 2007

Grades K -3

Liability Waivers/Acceptance of League Rules

Player/s Name: \_\_\_\_\_

Release of Liability: I understand that there is no medical insurance provided by OLOH or the NVJCYO. As the parent or legal guardian of the above named minor/s, I grant permission for this minor/s to participate in all activities of OLOH CYO Basketball program . I assume all risks and hazards to and from and while such activities are in progress. I, hereby, release and waiver all claims against OLOH, NVJCYO, or any ff the various county department of parks and recreation, organizers, officials, coaches and sponsors.

Emergency Medical Permission: Permission is hereby granted to provide first aid at the scene and/or to take my child/ren to an emergency room of any hospital in the event my child/ren is injured or appears injured while participating in this program. Permission is also granted for the hospital and its staff to provide treatment which a physician may prescribe for the well being of my child/ren.

Parent/Guardian Signature : \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian (Printed) : \_\_\_\_\_ Date: \_\_\_\_\_