HAMPTON TORNADOS

YOUTH FOOTBALL AND CHEERLEADER 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)

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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)

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ORGANIZATIONAL INFORMATION

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

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

Date Uniform Issued: ________________ **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***

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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***

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MEDICAL INFORMATION

	YES	***NO***
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**

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