



Season/Year: _____
Team: _____
Head Coach: _____



Williamsburg Starz Annual Registration & Health Form

Player Name: _____
Last First

Date of Birth: _____ **Player's Social Security Number:** _____

Player's city/county of residence: _____

Interested in receiving program financial assistance information: yes no

(if "yes," the Starz Treasurer will contact you with more information)

Player lives with: both parents father mother other (describe) _____

<p>Father's / guardian information:</p> <p>Name: _____</p> <p>Street: _____</p> <p>City: _____ Zip: _____</p> <p>Home Phone: _(_____)_____</p> <p>Work Phone: _(_____)_____</p> <p>Cell Phone: __ (_____)_____</p> <p>Email: _____</p> <p>2nd email: _____</p>	<p>Mother's / guardian information:</p> <p>Name: _____</p> <p>Street: _____</p> <p>City: _____ Zip: _____</p> <p>Home Phone: _(_____)_____</p> <p>Work Phone: _(_____)_____</p> <p>Cell Phone: __ (_____)_____</p> <p>Email: _____</p> <p>2nd email: _____</p>
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Family Physician: _____ **Dr. Office Phone:** () _____

Insurance Company: _____ **Policy # / ID #:** _____

In an emergency, if you cannot be reached, please notify:	o Check here if same as above.
Name: _____	Relationship: _____
Work Phone: () _____	Home Phone: () _____
	Cell Phone: () _____

Health History

1. Check any allergies player may have and briefly describe the reaction:

- | | |
|---|---|
| <input type="checkbox"/> Insect stings/bites _____ | <input type="checkbox"/> Seafood _____ |
| <input type="checkbox"/> Asthma (allergy induced) _____ | <input type="checkbox"/> Food (wheat, nuts) _____ |
| <input type="checkbox"/> Hay Fever _____ | <input type="checkbox"/> Penicillin _____ |
| <input type="checkbox"/> Other _____ | |

Check below if participant currently has or has had any of the following:

CONDITION	Past	Currently Has	CONDITION	Past	Currently Has
Heart Defect/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding/Clotting Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>			

Health History, Continued

1. Complete the following:

- a. Are there any specific activities to be encouraged, limited or avoided? o YES o NO
If, yes please explain: _____

- b. Does participant have a current tetanus shot? o YES o NO Date of shot: ___/___/___

- c. List current medications (please send with directions if to be administered during activities):

- e. I give permission for my child to be administered the following as needed for minor discomfort during Starz sponsored activities such as practices and tournaments: (check all that apply)

Tylenol Advil Benadryl Cough drops Sudaphin (Sudafed) Antacid Aleve
 other: _____

- f. Does your child have any special dietary considerations? o YES o NO
If yes, please provide detailed information: _____

- g. Provide any other important health related information about your child:

READ AND SIGN THE FOLLOWING:

This health history provided in this document is correct so far as I know. I understand that participation in Williamsburg Starz activities is entirely voluntary. I know and understand the risks and dangers involved with softball associated activities and I know and understand that unanticipated dangers might arise. I hereby release Williamsburg Starz and the City of Williamsburg (co-sponsor) from any responsibility for injury which might occur as a result of participation in Starz activities except for those determined to be a result of gross negligence on the part of Williamsburg Starz or the City of Williamsburg. I give permission for _____ to participate in all activities, except as noted. I, also give permission to authorized personnel to carry out such emergency diagnostic and therapeutic procedures as may be necessary for my child, and also permit such treatment procedures to be carried out at, and by, the local hospital(s) for my child in the event of an emergency. I understand that any medical expenses will be billed directly to me or my insurance company.

Parent/guardian signature

Date

MEDIA RELEASE:

I authorize Williamsburg Starz and/or the City of Williamsburg to use my child's name, voice, photographs and/or likeness in connection with audio-video productions, articles, or press releases for the promotion and/or encouraging public participation in the program. I understand that I will not be reimbursed in cash or in-kind now or in the future. Please sign in the space below if you agree to grant to the Williamsburg Starz and/or the City of Williamsburg permission to use you or your child's name, voice, and/or photographs in connection with any of their audio-video productions, articles, or press releases.

Parent / Guardian signature

Name (printed)