# Lower Bucks Lightning Basketball – 2011/2012 Registration

Player's Name: ______________________________ Birth date: __________________________ Sex: M or F

Grade (2011-2012 school year): ________________ School: _______________________________________

LBL Coach in 2011 (if applicable): ____________________________________________________________

I am interested in helping LBL as a volunteer? Yes No **NOTE: We NEED you!**

Mother's name: ______________________________ Father's name: ________________________________

Street: _____________________________________________________________________________________

City: ______________________________________ State: ___________ Zip: _________________________

Home phone: _______________________________ Cell phone: ___________________________________

Parent's email address (for club use only): _____________________________________________________

Doctor's name: ______________________________ Doctor's phone: _______________________________

Health Insurance Co.: _________________________ I.D. #: _______________________________________

Emergency contact name: ____________________ Emergency contact phone: _____________________

## Participants Medical History & Permission Statement - Must be completed by Parent or Guardian

Has your child ever been treated by a Doctor for, or experienced, any of the following? **Must circle "Yes" or "No":**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Head Injury: | No | Yes | Concussion: | No | Yes | Dizzy Spells: | No | Yes |
| Asthma: | No | Yes | Fainting: | No | Yes | Anemia: | No | Yes |
| Back Injury: | No | Yes | Diabetes: | No | Yes | Fatigue: | No | Yes |
| Heart Problems: | No | Yes | | | | | | |

Is your child allergic to any drugs, serums, adhesive tapes or insects? No Yes
Please explain: _____________________________________________________________________________

Is your child allergic to any food or other substances? No Yes
Please explain: _____________________________________________________________________________

Has your child ever been told not to participate in sports because of a health problem? No Yes
Please explain: _____________________________________________________________________________

Does your child take medication regularly? No Yes
Please list medication(s): _____________________________________________________________________

Has your child had any serious illness or operation in the past year? No Yes
Please explain: _____________________________________________________________________________

Is your child currently under a Doctor's care? No Yes
Please explain: _____________________________________________________________________________

Is there any medical condition that would limit your child's participation in our program? No Yes
Please explain: _____________________________________________________________________________

(Player's Name) ___________________________________ has my permission to participate in the Lower Bucks Lightning Basketball program. I hereby assume all risks associated with the participation of my child in the Lower Bucks Basketball program and agree to hold harmless the Lower Bucks Lightning organization, its officers, coaches, and participants for any and all claims for injuries arising out of participation in this program. I have completed and understand the details of this form and attest to its accuracy. I certify that my child has primary health insurance with the above carrier. I also give permission for my child to be examined and treated by a physician in case of emergency.

Signature (Parent / Guardian): ___________________________________ Date: _____________________

***Registration Fee for 9/1/11 to 8/31/12: $300.00***

Checks made out to: Lower Bucks Lightning Basketball
Mail to: Lower Bucks Basketball Group, P.O. Box 1142, Langhorne, PA 19047