Howie's Field of Dreams

Bambino Buddy Ball, Inc.

Roger N. Allen Baseball (Cal Ripken Baseball)

-Application to participate in Roger N. Allen Baseball (ages 5-20)-

Player's Name: _____ Player's Diagnoses: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Player's Current School: _____

Name of Players Sibling(s) in League: _____ , _____

Father's Name: _____ Cell: _____ Email: _____

Mother's Name: _____ Cell: _____ Email: _____

Player Jersey Size: YS☐ YM☐ YL☐ AS☐ AM☐ AL☐ AXL☐ Jersey Number (Pick 3): _____ , _____ , _____

Current Player:

New Jersey Needed:YS☐ YM☐ YL☐ AS☐ AM☐ AL☐ AXL☐ New Hat Needed: ☐

Player (check all that apply): ☐ Uses a wheelchair ☐ Wears glasses ☐ Uses a walker ☐ Wears hearing aids ☐ Uses crutches ☐ Has seizures

Please list any medication player takes:

_____ _____

_____ _____

_____ _____

Please list any allergies player has:

_____ _____

_____ _____

_____ _____

Emergency Contact(s)

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Parent(s) Consent

My child (player name): _____ is insured by the following company: _____ and has my permission to participate in the Roger N. Allen Baseball program under the supervision of the assigned coaches. In giving this consent, I do so with full understanding that the Roger N. Allen Baseball League and its staff assumes no financial liability for any accident or injury to my child, which may occur as a result of his/her participation in the program. I agree to hold Roger N. Allen Baseball harmless against any and every obligation, liability, and responsibility for damage to persons or property occurring during any league play and/or special event. I understand that my childs likeness may be used for promotional/media purposes such as league website, fliers, advertisements, commercials, newspaper and TV news, etc…..

Parent Signature: _____ Parent Signature: _____

Print Name: _____ Print Name: _____

Date: _____ Date: _____

Medical Release & Parent/Guardian Authorization

In case of an emergency, if family physician cannot be reached, I hereby authorize my child (player name): _____ (Date of birth): _____ to be treated by another qualified, licensed physician who is available.

Family Physician: _____ Phone: _____

Address: _____ City: _____ State: _____

Parent Signature: _____ Parent Signature: _____

Print Name: _____ Print Name: _____

Date: _____ Date: _____

We need your help!!!

In which of the following area(s) suit you best?

☐ Manager ☐ Coach ☐ League Officer ☐ Facilities ☐ Team Mom/Dad