SENIOR LEAGUE TRYOUT WORKSHEET – 2016

This worksheet must be presented before the tryout. If selected to a team, you will then be asked to register and pay on the Braintree Babe Ruth online website.

Player Information:

Player's Name:____ Date Of Birth:__________________

Address:____

Primary Telephone #:___________________________ Player Mobile:___________________________

Player Participates In Another Baseball Program? ☐ Yes, Program: ________________________

Parent/Guardian:______________________ Phone: ____________________ Mobile:__________________

No payment needed to Tryout. **If players are selected to a team, registration instructions will follow.**

Having been informed of the organization of the BRAINTREE BABE RUTH LEAGUE to provide supervised baseball tryout for boys/girls, I/We the parents/guardians of the above named candidate do hereby give our approval to his/her participation in and all of the activities during all tryouts. I/We hereby release, absolve, indemnify, and hold harmless, The BRAINTREE BABE RUTH LEAGUE, the organizers, sponsors, officers, and any supervisors appointed by them. I/We likewise release from responsibility, any person transporting my/our son/daughter for medical attention is needed.

Medical Release

Parent or Guardian Authorization:

In case of emergency, if family physician cannot be reached, I hereby authorize the player named above to be treated by Certified Emergency Personnel. (e.g. EMT, First Responder, E.R. Physician).

Family Physician: ____ **Phone:** ____________________

Address: ____

Hospital Preference: ____

In case of emergency contact:

____

Name Phone Relationship to Player

____

Name Phone Relationship to Player

Medical Information

Please note any medical conditions or allergies (including food allergies) we need to know about the participant:

ANY MEDICAL PROBLEMS: CIRCLE YES OR NO

If yes, please list any allergies/medical problems, including those that require maintenance medication. (e.g. Diabetic, Asthma, Seizure Disorder)

Please explain:

____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

____ ____________________________________

(Parent/Guardian Signature) (Date)

**I agree that I am the authorized parent/legal guardian, and I have legal capacity to agree to all terms in this document*