

L.O.Y.A.L. LACROSSE REGISTRATION FORM

CHILD'S LAST NAME: _____ FIRST NAME: _____
D.O.B.: _____ AGE: _____
PARENT/GUARDIAN NAME: _____
ADDRESS: _____ ZIP: _____
TELEPHONE: HOME: _____ WORK: _____ CELL/PAGER: _____
HAS YOUR CHILD PARTICIPATED IN L.O.Y.A.L. NO ___ YES ___, IF YES:

UNIFORM SIZE: (CIRCLE ONE): SHIRT YOUTH S M L XL ADULT S M L XL XXL

NO REFUNDS WILL BE GIVEN FOR WITHDRAWL FROM LACROSSE UPON START OF SEASON
I, THE UNDERSIGNED PARENT/GUARDIAN OF _____, WHO HAS BEEN REGISTERED TO PARTICIPATE IN THE LACROSSE PROGRAM SPONSORED BY THE MEDINA-L.O.Y.A.L., HERBY GIVE APPROVAL TO HIS/HER PARTICIPATION IN ANY AND ALL ACTIVITIES OF MEDINA-L.O.Y.A.L. RELATED TO THE SPORT IN WHICH HE/SHE IS PARTICIPATING. I UNDERSATND THAT INJURIES MAY OCCUR IN LACROSSE AND I HEREBY WAIVE, RELEASE AND AGREE TO HOLD HARMLESS MEDINA-L.O.Y.A.L., ITS OFFICERS, DIRECTORS AND OTHERS ASSOCIATED WITH IT IN ANY WAY, AS WELL AS OTHER PARTICIPANTS AND THEIR PARENTS/GUARDIANS, FROM ANY CLAIM ARISING OUT OF AN INJURY TO MY CHILD, EXCEPT TO THE EXTENT AND IN THE AMOUNT COVERED BY ADDICT OF LIABILITY INSURANCE HELD BY MEDINA-L.O.Y.A.L.. FURTHERMORE, I AGREE TO RETURN UPON REQUEST THE UNIFORM AND OTHER EQUIPMENT ISSUED TO MY CHILD BY MEDINA L.O.Y.A.L. IN AS GOOD OF CONDITION AS WHEN IT WAS RECEIVED, EXCEPT FOR NORMAL WEAR OR OTHERWISE TO PAY MEDINA L.O.Y.A.L. THE COST OF REPLACING ANY PORTION OF THE UNIFORM OR EQUIPMENT I DO NOT RETURN. I CONSENT TO HAVE THE ABOVE NAMED PARTICIPATE IN ANY MANDATORY FUND RAISING EVENTS.

DO YOU HAVE MEDICAL INSURANCE: NO ___ YES ___, IF YES INSURANCE COMPANY NAME AND POLICY NUMBER: _____
CHILD'S PHYSICIAN: _____ PHONE NUMBER: _____
DRUG SENSITIVITIES OR ALLERGIES: _____
OTHER MEDICAL/PHYSICAL/DEVELOPMENTAL CONCERNS: _____

MEDINA-L.O.Y.A.L. HAS INSURANCE TO COVER ALL THOSE (CHILDREN/ADULTS) WHO PARTICIPATE IN THE LACROSSE PROGRAM AND ARE NOT COVERED BY OTHER POLICIES, BUT THERE IS A \$150 DEDUCTIBLE, AND PARENTS MUST PAY ANY EXPENSES UP TO \$150 FOR ANY INJURY.

PLEASE READ MEDICAL INSTRUCTIONS: IF MY CHILD NEEDS MEDICAL ATTENTION, I CONSENT TO PROCEEDURES ORDERED BY THE MEDICAL OFFICER PRESENT IF IMMEDIATE TREATMENT IS NECESSARY TO SAVE MY CHILD'S LIFE OR PREVENT PERMANENT INJURY, ON THE UNDERSTANDING THAT EFFORTS WILL BE MADE TO CONTACT ME AND WILL CONTINUE TO BE MADE UNTIL I AM REACHED. I ACCEPT RESPONSIBILITY FOR ALL COSTS RELATED TO SUCH TREATMENT. IN THE EVENT OF A LESS SEVERE INJURY, WHICH DOES NOT REQUIRE IMMEDIATE TREATMENT, I RESERVE THE RIGHT TO BE CONSULTED ABOUT ANY MEDICAL PROCEEDURES EMPLOYED.

IN CASE OF EMERGENCY, ATTEMPT TO CONTACT IN THE FOLLOWING ORDER IF I CANNOT BE REACHED:
NAME: _____ PHONE # (H) _____ (W) _____ CELL/PGR _____
NAME: _____ PHONE # (H) _____ (W) _____ CELL/PGR _____
NAME: _____ PHONE # (H) _____ (W) _____ CELL/PGR _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PLEASE MAKE CHECKS PAYABLE TO: L.O.Y.A.L. LACROSSE AND RETURN COMPLETED REGISTRATION FORM AND A COPY OF CHILD'S BIRTH CERTIFICATE TO: L.O.Y.A.L. LACROSSE, 439 MAIN

STREET, MEDINA, NY 14103. * NO UNIFORMS WILL BE ISSUED WITHOUT BIRTH CERTICIATE AND FULL PAYMENT. * THERE IS A \$20 FEE FOR RETURNED CHECKS *

REGISTRATION FEE: \$65.00 per registrant.

L.O.Y.A.L. USE ONLY

REG. FEE PAID \$ ___ **CASH** ___ **CHECK #** _____ **TEAM** _____ **REGISTAR INITIALS** _____