Murphysboro Baseball Inc.
Champions League Registration

Please print all information, complete the **Medical Release Form**,
And return to MBI or mail to MBI c/o Cindy Reiman, P.O. Box 106, Murphysboro, IL 62966.

Player Name: _____

Legal Address: _____

City, State, Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Shirt Size: Youth – S M L XL Adult- S M L XL Hat Size: Child Adult

Parent/Legal Guardian: _____

Home Phone: _____ Cell: _____ Work: _____

Attached Medical Release Form MUST be completed and turned in. Private Insurance is not required.

1. I/we the parents/guardians know that participation in the Champions League baseball/softball team may result in serious injuries and that protective equipment does not prevent all injuries to players. I/we knowingly do hereby waive, release, absolve, indemnify, and agree to hold harmless the local MBI league, organizers, sponsors, supervisors, and/or participants from any claim arising out of any injury to my/our child whether the result of negligence or for any other cause.

2. I/we understand that my/our child must be eligible under the residence and age regulations to participate in this program.

3. I/we agree to provide proof of legal residence of the above named player if required.

4. I/we permit MBI to use and release photographs and recorded medium of this child in promoting or advertising the Champions League of MBI.

Signature of parent/legal guardian: _____ Date: _____

This program requires volunteers! Please advise if you are willing to volunteer your assistance in one of the following manners: (background checks are required for all coaches)

Head Coach Assistant Coach Field Assistant Team Coordinator Sponsor

Champions League Medical Release Form

Player's Name _____ Date of Birth: _____

Parent/Legal Guardian Authorization: _____

In case of emergency, if a family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e EMT, Emergency Room Physician, etc.).

Family Physician: _____ Phone: _____

Address: _____

Hospital of Preference: _____

In case of emergency contact:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Disability or special condition of player: _____

Special needs: walker wheelchair buddy assistance required other: _____

Allergies/medical needs, including those requiring maintenance medication: _____

_____

_____

The purpose of the above listed information is to ensure that medical personnel have details of the medical needs of your child which may interfere with or require the altering of emergency medical treatment.

Date of last Tetanus Toxic Booster, if known: _____

Allergic Reaction to bee sting? Yes No If yes, kit available with parent/child? Yes No

Child's insurance information: _____

Provider: _____ Policy Number: _____

Provider Number: _____ I.D. Number: _____

Signature of parent/legal guardian: _____ Date: _____