DELTA LITTLE LEAGUE OF STOCKTON (209) 469-3055
WWW.DELTALL.COM

PLAYER REGISTRATION FORM

Name:_____
First Last
Date of Birth:____/____/____Age:____ Sex: M or F Lives with: Mother or Father or Both
Home Phone:_____Alt. Phone:_____School:_____
Address:_____
Number Street City Zip Code
Parent E-Mail Address(es)_____;_____
Did Child Play in Delta Little League Last year? Yes No If Yes, What Team?_____
Shirt Size:_____

PARENT/GUARDIAN INFORMATION

Father's Name:_____
First Last
Address:_____
("Same" if as above) Number Street City Zip Code
Work Phone:_____Home Phone:_____
Occupation:_____
Mother's Name:_____
Address:_____
("Same" if as above) Number Street City Zip Code
Work Phone:_____ Home Phone:_____
Occupation:_____

MEDICAL RELEASE

Parent or Guardian Authorization: Date:_____

IN THE EVENT OF AN EMERGENCY, IF THE FAMILY PHYSICIAN CAN NOT BE REACHED, I HEREBY GIVE AUTHORIZATION TO OBTAIN MEDICAL TREATMENT FOR THE ABOVE NAMED MINOR. THIS AUTHORIZATION COVERS ANY EMERGENCY TREATMENT DEEMED NECESSARY BY THE ATTENDING PHYSICIAN, NURSE PRACTIONER, NURSE OR EMERGENCY MEDICAL TECHNICIAN. I UNDERSTAND THAT I, THE UNDERSIGNED, AM RESPONSIBLE FOR ALL MEDICAL COSTS AND THAT DELTA LITTLE LEAGUE'S AND LITTLE LEAGUE BASEBALL'S INSURANCE IS THAT OF CO-INSURANCE AND SHALL NOT BE CONSIDERED PRIMARY INSURANCE. THERE IS A PER INCIDENT DEDUCTIBLE AND COVERAGE LIMITATIONS.

Family Physician:_____ Phone:_____
Date of last Tetanus Toxoid Booster:_____
Insurance Provider:_____I.D./Group #:_____

Please list any Allergies/medical problems, including those requiring maintenance medication. (i.e., Diabetes, Asthma, Seizure Disorder)

Medical Diagnosis	Medication	Dosage	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parent/Guardian Signature:

LITTLE LEAGUE USE ONLY

Birth Certificate Verified:_____Date:_____L.L. Age:_____Map Coord:_____
Payment Method: Cash Check Amount Paid:_____ Cash Receipt #:_____Child #:____of____
Player#:_____Family #_____Division:_____Input date/intials:_____/_____