

CK # _____

CASH _____

SUWANNEE VALLEY LEAGUES INC. YOUTH REGISTRATION FORM

(FORM MUST BE COMPLETELY FILLED IN)
Cheerleading 2008

PLAYER'S NAME : _____

PHYSICAL ADDRESS: _____

MOTHER'S HOME PHONE # _____ CELL # _____ WORK # _____

FATHER'S HOME PHONE # _____ CELL # _____ WORK # _____

MOTHER'S E-MAIL ADDRESS : _____

FATHER'S E-MAIL ADDRESS : _____

PLAYER'S D.O.B. : _____ RECEIPT OF COPY OF BIRTH CERTIFICATE : YES ___ NO ___

**UNIFORMS WILL NOT BE LOANED UNTIL SIGN-UP FEE HAS BEEN PAID & BIRTH CERT. RECEIVED.
BOTH WILL REMAIN THE PROPERTY OF SVL UPON END OF SEASON.**

WILL YOU FIND A SPONSOR FOR YOUR TEAM? (\$300.00) YES ___ NO ___

WILL YOU BE A HEAD COACH FOR YOUR TEAM? YES ___ NO ___ SHIRT SIZE: _____

WILL YOU BE AN ASST. COACH FOR YOUR TEAM? YES ___ NO ___ SHIRT SIZE: _____

PRESS RELEASE AUTHORIZATION:

I HEREBY AUTHORIZE SVL INC. TO DEPICT IN PERPETUITY THE ABOVE NAMED PLAYER'S LIKENESS, IMAGE, NAME, SIGNATURE, AND OTHER INDICIA OF MY RIGHTS OF PUBLICITY IN PHOTOGRAPHIC OR OTHER WORKS APPEARING IN ANY AND ALL MEDIA FOR PURPOSES OF PROMOTING, ADVERTISING, OR MARKETING CURRENT OR FUTURE EVENTS RELATED TO SVL INC. AND I AGREE THAT SUCH IMAGES MAY BE USED FOR THAT PURPOSE WITHOUT COMPENSATION.

MEDICAL TREATMENT INFORMATION:

BY MY SIGNATURE BELOW, I AM THE LEGAL PARENT / GUARDIAN OF THE PLAYER NAMED AT THE TOP OF THIS FORM. I TAKE RESPONSIBILITY FOR THE CLAIMS HERETOFORE OR HEREAFTER ARISING KNOWN OR UNKNOWN, FROM THE PLAYER'S PARTICIPATION IN THE PROGRAMS OF S.V.L. INC. / G.C.R.A. INC. I KNOWINGLY, VOLUNTARILY AND EXPRESSLY RELEASE THE VOLUNTEERS CONDUCTING THE PROGRAMS AND S.V.L. INC. / G.C.R.A. INC. FROM ALL LIABILITY ON CLAIMS ARISING ON SUCH MATTERS. I FURTHER AUTHORIZE ANY PHYSICIAN, HOSPITAL, OR DENTIST TO PROVIDE ANY EXAMINATION AND / OR TREATMENT FOR THE ABOVE NAMED PLAYER. I WILL BE RESPONSIBLE FOR ALL THE REASONABLE EXPENSES INCURRED FOR SUCH TREATMENT OR MEDICAL CARE BEYOND THE SECONDARY INSURANCE PROVIDED BY S.V.L. INC. / G.C.R.A. INC.

MEDICAL CONDITIONS OR ALLERGIES: _____

PHYSICIAN : _____ PHONE # _____

MEDICAL INSURANCE COMPANY'S NAME : _____

PROVIDER'S ADDRESS : _____

POLICY # : _____ EXPIRATION DATE _____

PARENT / GUARDIAN NAME PRINTED : _____

PARENT / GUARDIAN SIGNATURE : _____ DATE : _____

(CODE OF ETHICS)