Clinton Community Youth Athletics

Basketball for the children of the Town of Clinton and the Boro of Glen Gardner
A Member of the North Hunterdon Basketball League

2023/2024 Season

REGISTRATION FORM for ALL GRADES
RETURN FORM TO **CPS MAIN OFFICE** BY **Tuesday Nov. 14th, 2023**
Evaluations for Grades 3-8: Wednesday evening November 15, 2023
In the CPS Gym Grades 3 /4 Boys and Girls 6:45 to 7:45 PM - Grades 5/6 & 7/8 7:45 to 8:45 PM
ONE NIGHT ONLY

Registration FEES: **$120** per Child **GRADES 3-8** $**85** per Child for GRADES **K-2**.
Make checks payable to: **Clinton Community Youth Athletics**
Volunteer Activities: (check all that apply) Please be active in the Program!

*Coach: _____ *Asst. Coach:_____ **(Parents Only for Coaching)** ****WE ARE IN NEED OF COACHES****
Referee: I have a child that is 14 years old or older that would be interested in becoming a Ref for Grade ¾ Games:
Or to work scorer table. ****WE ARE IN NEED OF GAME DAY HELP****
Yes___
Please contact Bill Colantano with questions at 973-432-3519 or email bcolantano@yahoo.com

PLAYER INFORMATION:
LAST NAME: _____FIRST NAME_____
Circle: BOY or GIRL DOB: _____/__ ___ /_____ GRADE:_____
REQUIRED – DUE TO THE CURRENT SITUATION WITH LOW INVENTORY AND LONGER LEAD TIMES JERSEYS WILL BE PRE-ORDERED. PLEASE SELECT A SIZE AND WE WILL DO OUR BEST TO FIT YOUR CHILD YS, YM, YL, AS, AM, AL, XL, XXL (circle one)

STREET ADDRESS:_____

E-MAIL ADDRESS:_____ Alt:_____
We MUST have e-mail addresses for communication purposes. Please provide at least one per family.
Emergency Contact Information:
Mother:_____ Home Phone No:_____ Cell Phone No:_____
Father:_____ Home Phone No:_____ Cell Phone No:_____
Alternate:_____ Home Phone No:_____ Cell Phone No:_____
Insurance Carrier:_____Policy No:_____
Family Doctor:_____Phone No:_____
Family Dentist:_____ Phone No:_____
Preferred Hospital:_____
Medical allergies, chronic illnesses, or other medical conditions: (List all that apply; Use back of form if needed)_____
_____

Medical Treatment Authorization:

As a parent and/or guardian of _____, a minor, I hereby authorize the treatment by a qualified and licensed doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger my child's life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. This release is completed and signed of my own free will for the sole purpose of authorizing treatment under emergency circumstances in my absence.
Parent/Guardian Signature: _____ Date:_____
This form along with payment should be returned to the **CPS Main Office**. Thank You.