



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



2016/2017 SEASON

REGISTRATION FORM for ALL GRADES

RETURN FORM TO **CPS MAIN OFFICE** BY **Wednesday Nov. 16th, 2016**

Evaluations for Grades 3-8: Wednesday evening November 16th

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: \$95 per Child **GRADES 3-8** \$75 per Child for **GRADES K-2** Kindergarten is now included!

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**)

*Rutgers S.A.F.E.T.Y. Training Required. Have you been certified? Yes _____ No _____

Referee: I have a child that is 14 years old that would be interested in becoming a Ref for Grade 3/4 Games: **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 - We will fit your child at evaluation day, so attendance is important. If your child cannot come please indicate shirt size here: 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**. Thanks!