



**NORTH HILLS BOYS LACROSSE CLUB  
REGISTRATION FORM**

Player's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

School Attending \_\_\_\_\_

Have you played Lacrosse before? \_\_\_\_ If yes, where and what position? \_\_\_\_\_

Father/Male Guardian: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Home Ph: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

Mother/Female Guardian \_\_\_\_\_ Work Ph: \_\_\_\_\_ Home Ph: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_

In case of an emergency, Contact: First Choice \_\_\_\_\_  
(name & phone)

Second Choice \_\_\_\_\_ Third Choice \_\_\_\_\_  
(name & phone) (name & phone)

**PROOF OF INSURANCE**

Insurance Carrier: \_\_\_\_\_ Policy No. \_\_\_\_\_ Effective Date \_\_\_\_\_

**Insurance Requirements:** The player and his guardians named above understands and agrees that primary medical insurance coverage is required to be provided by the player for the period from the execution date of this "Proof of Insurance" for one year or December 1 of the following year, which ever comes last, in conjunction with the Player's participation in any field lacrosse playing activity (including, without limitation, practices, scrimmages, league regular season, tournament, playoff, and all-star games).

**Change in Insurance Status:** In the event that the Player's primary medical insurance coverage terminates during this period, the Player agrees to immediately withdraw from participation in all playing activities and notify the club of the change in insurance status.

**Failure to Provide Insurance:** No club member may permit any Player to participate in any lacrosse activity (including, without limitation, practices, scrimmages, league regular season, tournament, playoff, and all-star games) until and unless the Club/Association has received Proof of Insurance in accordance with its rules and regulations.

**I acknowledge and agree to these terms and conditions. I also authorize the above insurance company to provide the North Hills Lacrosse Club with all information necessary to verify my medical coverage.**

Insured \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_