

APPLICATION TO PLAY WALLINGTON JUNIOR FOOTBALL/CHEERLEADING

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ GRADE IN SEPT: \_\_\_\_\_

EMERGENCY PHONE NO.: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

TEAM LEVEL \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

PARENT EMAIL: \_\_\_\_\_

I/We, the parent(s)/guardian(s) of the above named candidate for a position on the Wallington Junior Football Team hereby give my/our approval to his/her participation in any and all Football League activities. I/We assume all risks and hazards incidental to such participation including transportation to and from the activities (if necessary), and I/We do hereby waive, release, absolve indemnify and agree to hold harmless the Wallington Junior Football League, Meadowlands Football League, the organizers, sponsors, coaches, supervisors, participants, and persons transporting my/our son/daughter to or from any activities, for any claim arising out of any injury to my/our son, whether the result of negligence or for any other cause, except to the amount and extent covered by accident or liability insurance.

I/We certify that \_\_\_\_\_ is in good physical condition. I/We further agree that the Wallington Junior Football League is under no obligation to provide a physical examination or other evidence of fitness to participate in this program, the same being our sole responsibility.

**I/We agree as to return upon request the uniform and other equipment issued to my/our child in as good condition as when received, except for normal wear and tear. I/We understand if we do not return said uniform/equipment I/we am/are held responsible for replacing said uniform/equipment.**

**I/We will furnish a certified birth certificate of the above named candidate before September 1<sup>ST</sup> of current playing season. (same to be returned after weigh in.)**

THE FOLLOWING QUESTIONS MUST BE COMPLETED BY BOTH PARENTS; FAILURE TO DO SO MAY RESULT IN REJECTION OF APPLICANT.

FATHER'S PLACE OF EMPLOYMENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

MOTHER'S PLACE OF EMPLOYMENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

The accident insurance provided by Wallington Junior Football is excess of all other valid and collectible individual or group insurance in force at the time of accident causing a loss. If there is no other coverage available this coverage will pay the covered expenses up to the amount of benefit less a \$100 deductible. All medical bills must first be submitted to your plan and upon receipt of the Explanation of Benefits (EOB) from your insurance, our plan will then consider the uncovered expenses.

Signature of Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE PRINT**

MOTHER'S NAME: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

**MEDICAL TREATMENT FORM**

In the event of an emergency occurring while my son/daughter is participating in a Wallington Junior Football League sponsored practice, performance or trip, I grant my permission to the organization and its volunteers to take whatever action necessary. In the event that I cannot be reached,

I hereby authorize the organization and/or its volunteers to give consent for my son/daughter, \_\_\_\_\_ to receive medical treatment at \_\_\_\_\_ hospital.

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Person to be notified other than parent or guardian in an emergency:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

If you **DO NOT** grant permission or authorization for consent to medical treatment, what procedure should be followed? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I/We carry Medical and Hospitalization Insurance: Yes: \_\_\_\_\_ No: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical Information: circle all those apply**

Heart conditions or disease	YES	NO	Asthma	YES	NO
Diabetes	YES	NO	Allergic to medication	YES	NO
Convulsion Disorder	YES	NO	Allergic to insect bites	YES	NO

State allergies: \_\_\_\_\_

Date of Last Tetanus Shot: \_\_\_\_\_

Additional Medical History that may be helpful: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Any medications currently receiving: \_\_\_\_\_