

REGISTRATION FORM
SUPERSONICS TRACK REGISTRATION

NAME _____ AGE _____ SEX _____ DATE OF BIRTH _____

ADDRESS _____

(include street, city, and zip code)

SCHOOL _____ GRADE _____ HT _____ WEIGHT _____

PARENT/GUARDIAN _____ EMAIL _____

HOME PHONE# _____ WORK PHONE# _____

EMERGENCY PHONE# _____ REGISTRATION FEE \$50.00 (non-refundable)

STATEMENT OF PURPOSE

THE SUPERSONICS TRACK CLUB REPRESENTS THE EFFORTS OF CONCERNED PROFESSIONALS & NON-PROFESSIONALS WHO BELIEVE THAT INCORPORATING ATHLETIC ABILITY INTO FRIENDLY ORGANIZED COMPETITION RESULTS IN THE EFFECTIVE DEVELOPMENT OF YOUTH IN ASSUMING PRODUCTIVE AND RESPONSIBLE ROLES WITHIN THEIR HOMES, SCHOOLS, AND COMMUNITIES.

AGREEMENT

UPON SIGNING THIS MEMBERSHIP APPLICATION YOU AS A PARENT OR GUARDIAN ARE 1) DEMONSTRATING SUPPORT FOR THE FOREMENTIONED STATEMENT OF PURPOSE: 2) AGREEING TO PROVIDE REINFORCEMENT AT HOME IN THE IMPORTANCE OF PROMPTNESS, HARD WORK, FAIR PLAY, AND TEAM WORK: 3) AGREEING TO WAIVE ALL CLAIMS AGAINST CLUB OFFICIALS, AND CLUB SUPPORT ORGANIZATIONS.

MEDICAL HISTORY

FAMILY DOCTOR _____ PHONE# _____

INSURANCE CO/HEALTH PLAN _____ POLICY# _____

CHECK THE FOLLOWING. USE YES OR NO AS REQUIRED AND GIVE APPROPRIATE DATES.

EAR INFECTION _____ ALLERGIES _____ DISEASES _____

RHEUMATIC FEVER _____ HAY FEVER _____ CHICKEN POX _____

CONVULSIONS _____ POISON IVY _____ MEASLES _____

DIABETES _____ INSECT STING _____ GERMAN MEASLES _____

ABNORMAL BEHAVIOR _____ PENICILLIN _____ MUMPS _____

OTHER DRUGS _____ ASTHMA _____

CHRONIC RECURRING ILLNESS _____ DATE OF MAJOR OPERATIONS _____

ANY OTHER DISEASE OR EXPLANATION OF ABOVE ITEMS: _____

DATE OF LAST PHYSICAL _____

PARENT/GUARDIAN AUTHORIZATION

THE MEDICAL HISTORY IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THE APPLICANT HAS MY PERMISSION TO PARTICIPATE IN ALL RUNNING EVENTS OF THE TRACK CLUB, EXCEPT THOSE CHOSEN BY ME OR A PHYSICIAN. IN CASE OF AND EMERGENCY, I HEREBY AUTHORIZE THE OR AN AUTHORIZED ADULT OFFICER TO HOSPITALIZE, SECURE PROPER MEDICAL TREATMENT FOR, AND TO AUTHORIZE INJECTIONS, ANESTHESIA, OR SURGERY FOR MY CHILD, WHOSE NAME APPEARS ABOVE.

SIGNATURE OF PARENT/GUARDIAN DATE PRINT NAME HERE

Print Name

Signature

Date