

## Lower Bucks Lightning Basketball – 2009/2010 Registration

Player's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: M or F  
Grade (2009-2010 school year): \_\_\_\_\_ School: \_\_\_\_\_  
LBL Coach in 2009 (if applicable): \_\_\_\_\_  
Mother's name: \_\_\_\_\_ Father's name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Parent's email address (for club use only): \_\_\_\_\_  
Doctor's name: \_\_\_\_\_ Doctor's phone: \_\_\_\_\_  
Health Insurance Co.: \_\_\_\_\_ I.D. #: \_\_\_\_\_  
Emergency contact name: \_\_\_\_\_ Emergency contact phone: \_\_\_\_\_

### Participants Medical History & Permission Statement - Must be completed by Parent or Guardian

Has your child ever been treated by a Doctor for, or experienced, any of the following? Please circle "Yes" or "No":

Head Injury:	No	Yes	Concussion:	No	Yes	Dizzy Spells:	No	Yes
Asthma:	No	Yes	Fainting:	No	Yes	Anemia:	No	Yes
Back Injury:	No	Yes	Diabetes:	No	Yes	Fatigue:	No	Yes
Heart Problems:	No	Yes						

Is your child allergic to any drugs, serums, adhesive tapes or insects? No Yes

Please explain: \_\_\_\_\_

Is your child allergic to any food or other substances? No Yes

Please explain: \_\_\_\_\_

Has your child ever been told not to participate in sports because of a health problem? No Yes

Please explain: \_\_\_\_\_

Does your child take medication regularly? No Yes

Please list medication(s): \_\_\_\_\_

Has your child had any serious illness or operation in the past year? No Yes

Please explain: \_\_\_\_\_

Is your child currently under a Doctor's care? No Yes

Please explain: \_\_\_\_\_

Is there any medical condition that would limit your child's participation in our program? No Yes

Please explain: \_\_\_\_\_

(Player's Name) \_\_\_\_\_ has my permission to participate in the Lower Bucks Lightning Basketball program. I hereby assume all risks associated with the participation of my child in the Lower Bucks Basketball program and agree to hold harmless the Lower Bucks Lightning organization, its officers, coaches, and participants for any and all claims for injuries arising out of participation in this program. I have completed and understand the details of this form and attest to its accuracy. I certify that my child has primary health insurance with the above carrier. I also give permission for my child to be examined and treated by a physician in case of emergency.

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

**Registration Fee (9/1/09 to 8/31/10): \$225.00 before 12/31/09 or \$250.00 after 12/31/09**

Checks made out to: Lower Bucks Lightning Basketball  
Mail to: Lower Bucks Basketball Group, P.O. Box 1142, Langhorne, PA 19047