

SPORTS REGISTRATION FORM

(Updated 1-Feb-21)

Name of Child (Last, First, MI)	AGE _____ DOB _____ (DD/JAN/YYYY)EX. 12 Jan 2005	Male _____ Female _____	SPORT (one sport only)
Experience	School Grade	Uniform Sizes (S,M,L, etc.) JERSEY (S) (M) (L) Shorts/Pants(S) (M) (L)	Day Time Telephone #
Parent/Legal Guardian/Sponsor Name/Relationship	Rank	Duty Phone #	Participant's Street Address
Other than Parents Emergency Contact Name	Emergency Contact's Phone #	Participant's Height Participant's Weight	Participant's City, St., Zip Code
Participant School		(Golf only) Homeroom Teacher	() Parent's Cell Phone #
Updated Shot Record with Flu shot _____	Golf only Right Handed () Left Handed ()		DO YOU HAVE GOLF CLUBS? Yes () No () Golf only

(PLEASE PRINT)

I, _____ do hereby give the bearer authority to request emergency medical treatment for my child, _____ in the event he/she is injured while taking part in a Youth Services program. This authorization shall expire one year from this date.

Signature of Parent/Guardian _____ Date: _____

The child will not participate in a YP sports program unless they have:

(1) **A valid shot record to include this season's Flu shot; a physical exam on file with the YC at the time of registration (Exams and shot records are valid for a one year period and may NOT expire before the end of the current sports season).**



(2) **Paid sports registration fees.**

Refund Policy: Participants will be considered (Medical or PCS) for refund if the season has not started and no cost has occurred. Once the season has started, including practices, a refund will only be given for medical emergency reasons supported by a Doctor's note

Request: Parents may request that their children play on the same team if they are in the same age group. Request must be written above the heading of the registration packet.

Uniform Sizes: Uniform size must be written on the Registration packet in the appropriate box.
If sizes are not listed, uniforms Will Not be ordered.

LIABILITY RELEASE

I, the undersigned, in consideration of the services which my child is to receive from the youth center and the Moral Support Fund, a non-appropriated fund instrumentally of the United States Government, hereby expressly assume the risk of death, bodily injury or property damage resulting from the simply negligence of the fund, its employees, coaches and agents in the operation of the Youth Sports program and any activities relative thereto, including the furnishing of transportation. This does not preclude me from resources that I may have for the injury of my child resulting from the willful misconduct or recklessness of the employees, coaches, or agents.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

E-MAIL ADDRESS _____

RECEIPT# _____ DATE _____ AMOUNT _____

YC STAFF INITIALS _____ DATE OF PHYSICAL _____ DATE ATTENDED ORIENTATION _____

SPORTS DIRECTOR INITIALS _____ FLU SHOT/SHOT RECORD _____

PARENT'S CODE OF ETHICS

I HEREBY PLEDGE TO PROVIDE POSITIVE SUPPORT, CARE, AND ENCOURAGEMENT FOR MY CHILD PARTICIPATING IN YOUTH SPORTS BY FOLLOWING THIS PARENT'S CODE OF ETHICS PLEDGE.

- I will encourage good sportsmanship by demonstrating positive support for all players, coaches, and officials at every game, practice, or other youth sports event.
- I will place the emotional and physical well-being of my child ahead of a personal desire to win.
- I will insist that my child play in a safe and healthy environment.
- I will support coaches and officials working with my child, in order to encourage a positive and enjoyable experience for all.
- I will demand a sports environment for my child that is free of drugs, tobacco, and alcohol, and will refrain from their use at all youth sports events.
- I will remember that the game is for youth NOT FOR ADULTS.
- I will do my best to make youth sports fun for my child.
- I will ask my child to treat other players, coaches, fans, and officials with respect regardless of race, sex, creed, or ability.
- I promise to help my child enjoy the youth sports experience by doing whatever I can, such as being a respectful fan, assisting with coaching, or providing transportation.
- I will require that my child's coach be trained in the responsibilities of being a youth sports coach and that the coach upholds the Coaches' Code of Ethics.
- I will read the NYSCA National Standards for Youth Sports and do what I can to help all youth sports organizations implement and enforce them.

(Parents Signature)

(Parent Signature)

(Date)

PHOTOGRAPHIC RELEASE

I _____ DO / DO NOT HEREBY GRANT AND CONVEY TO BARKSDALE AFB YOUTH PROGRAMS ALL RIGHTS, AND INTEREST IN ANY AND ALL PHOTOGRAPHIC IMAGES AND VIDEO OR AUDIO RECORDINGS MADE BY MY SON/DAUGHTER'S DURING ACTIVITIES INCLUDING, BUT NOT LIMITED TO, ANY ROYALTIES, PROCEEDS, OR OTHER BENEFITS DERIVED FROM SUCH PHOTOGRAPHS OR RECORDINGS.

SIGNATURE _____

BARKSDALE YOUTH PROGRAMS
PHYSICAL EXAMINATION FOR YOUTH SPORTS

Please print: _____
(Participant's Last Name) (First Name) (Middle Initial)

TO BE COMPLETED BY EXAMINING PHYSICIAN ONLY:

1. Heart Satisfactory Unsatisfactory (circle one)
2. Lungs Satisfactory Unsatisfactory (circle one)
3. Blood Pressure: _____ Pulse: _____ Height: _____
Weight: _____ Vision: R- _____ L- _____
4. Is there evidence of a Hernia? _____
Would athletic competition result in injury? _____
5. Are there any apparent cavities in any teeth? _____
6. Are there any known allergies? _____
7. Are there any known illnesses or pre-existing conditions ie. ADHD, Autism, or any other condition that may require additional training for our volunteer staff.

Please list any know conditions _____

I certify that I have on this date examined the above individual and recommend him/her as being physically capable to compete in supervised athletics that are NOT crossed out below.

- Start Smart: Basketball, Soccer, Tee-Ball, Golf
- Youth Basketball, Soccer, Tee-Ball, Baseball, Golf, Cheerleading, Volleyball, Bowling, Archery
- Youth must have a up to date shot record to include the Flu shot.

NOTE: The examining physician's signature and stamp are required.
This form is to be completed and filed in the Barksdale Youth Programs Sports Office prior to participation in any of the above listed sports.

Date Signature of Examining Physician

Credit Card Recurring Payment Authorization Form

Schedule your payments to be automatically charged to your credit card. Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

Here's How Recurring Payments Work:

You authorize regularly scheduled charges to your Visa, or MasterCard. You will be charged each billing period for the total amount due for that period. A receipt will be emailed to you and the charge will appear on your credit card statement. You agree that no prior-notification will be provided if the total payment is under the amount authorized below. If your bill is more than that amount, or the payment date changes, you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I, _____ authorize _____ to charge my credit card indicated (full name) below on:

The first of each month for payment in the amount of _____.

The 1st and 15th of each month for payment in the amount of _____.

The first Monday of each week for payment in the amount of _____.

Open Recreation Membership Agreement _____ Weekly _____ Monthly _____ Yearly

YP Sports Registration ONE TIME Payment in the amount of _____.

I understand that I will only receive advance notice of the charge if it exceeds an amount different than authorized.

Billing Address: _____ Phone Number: _____

City, State, Zip _____ Email: _____

First and Last Name

Signature

Date

I authorize the above named business to charge the credit card Indicated In this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain In effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account. Information or termination of this authorization is needed at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I understand that it is my responsibility to update the card information on file in order to prevent any declines. If my card does decline, I agree to pay the \$10 decline. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

Account Type: _____ Visa _____ MasterCard

Cardholder Name: _____

Card Number: _____

Expiration Date: _____ **CVV (3 Digit number on back of card):** _____