



RBI PROGRAM REGISTRATION AND MEDICAL CONSENT FORM

Baseball _____
Softball _____
LEAGUE NAME

Junior Div.
Senior Div.

Attach two (2) head shots here using a paper clip; alternatively, coaches may submit photos for entire team electronically

PLAYER INFORMATION

Name _____ Social Security Number _____ - _____ - _____
(LAST) (FIRST) (M.I.)

Permanent Address: _____
City _____ State _____ Zip _____ School _____
HS Graduation Year _____ Birthdate _____
Country of Origin _____

How long have you lived in the United States? _____ (years)
Ethnic Origin: Asian Black Latino Native American White Other _____
Name of Parent(s), Spouse, or Guardian (circle one) _____

Address _____
(no.) (street) (city) (state) (zip) (country)

Telephone: Work (_____) _____ Home (_____) _____
Cell (_____) _____

IN CASE OF EMERGENCY, CONTACT THE FOLLOWING INDIVIDUAL IF THE PERSON ABOVE CANNOT BE REACHED:

Name _____ Relationship _____

Address _____
(no.) (street) (city) (state) (zip) (country)

Telephone: Work (_____) _____ Home (_____) _____
Cell (_____) _____

Name of Physician or Clinic that you usually consult for medical care: _____

Address _____
(no.) (street) (city) (state) (zip) (country)

INSURANCE INFORMATION

Health Insurance Company Name _____

Address _____
(no.) (street) (city) (state) (zip) (country)

Telephone: Work (_____) _____

Policy Number _____

Subscriber Name _____

Social Security Number _____ - _____ - _____



PERMISSION FOR TREATMENT IN CASE OF IMMEDIATE NEED

If your son/daughter is a minor (under 18 years of age), you as a parent or legal guardian must sign this consent form so that the RBI Program can provide appropriate diagnosis and treatment and emergency health service procedures may be promptly carried out with no unnecessary delay. Without a signed permission for treatment, your minor son/daughter cannot receive treatment unless his/her presenting condition is exempted from requiring parental consent and/or notification. Even with a signed permission for treatment, we will attempt to contact and fully inform you as parent legal guardian before performing any major diagnostic/treatment procedure except in an emergency. It should be understood that under certain circumstances your son/daughter will be transported for diagnosis and treatment.

I certify that the foregoing information is true and complete to the best of my knowledge. I give my permission to the RBI Program to furnish such diagnostic, therapeutic, voluntary immunization, and/or operative procedures and/or transportation as may be deemed necessary by the RBI Program for my son/daughter who is under the age of 18 years. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as the result of treatment or examination. I further acknowledge that the terms of the RBI program player release & waiver (including, without limitation, the section titled RELEASE FROM LIABILITY AND COVENANT NOT TO SUE) are hereby incorporated by reference.

Name of Parent/Guardian (please print)

Signature of Parent/Guardian

Date

Signature of Player

Date