



Pleasanton Cavaliers RFC

2009 REGISTRATION FORM

PLEASE COMPLETE IN INK NEATLY



Player Name: _____ Date of Birth: Mo. ____ Day ____ Year ____
First Last

Email Address: _____ Cell phone number _____

Lives with: **Father / Mother / Both** (Please Circle ONE)

Weight: _____ Height _____ School _____ Grade _____

FATHER

MOTHER

Name: _____
First Last

Name: _____
First Last

Street Address: _____

Street Address: _____

City: _____

City: _____

State: _____ Zip: _____

State: _____ Zip: _____

Home Phone: (____) _____ - _____

Home Phone: (____) _____ - _____

Day Phone: (____) _____ - _____

Day Phone: (____) _____ - _____

MEDICAL INFORMATION/RELEASE

Doctor's Name: _____ Phone: _____

Doctor's Address: _____ Hospital: _____

Medical Conditions, Allergies/etc.: _____

Insurance Carrier: _____ Policy/I.D.#: _____

If the above listed parents are not available, CONTACT:

Name: _____ Phone: _____ Relationship: _____

CONSENT



I, the parent/guardian of the registrant, a minor, agree that I and the registrant will abide by the rules of the Pleasanton RFC. Recognizing the possibility of physical injury associated with rugby and in consideration of the Cavaliers accepting the registrant for its rugby program, I hereby release, discharge and/or otherwise indemnify Pleasanton RFC, its sponsors, its employees and associated personnel, including the owners of fields and facilities utilized for the program, against any claim by or on behalf of the registrant as a result of the registrant's participation in the program.

Parent/Legal Guardian Name (PLEASE PRINT)

Signature: _____ Date: _____

CONSENT FOR MEDICAL TREATMENT (MINOR)

As the parent or legal guardian of the above named player, I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my dependent.

Parent/Guardian Signature _____ Date: _____