HCASF Registration

PO Box 562, Burnet, TX 78611

Sport/Program_____

Fall/Winter/Spring/Summer Year_____

For League use only
AMT PD:_____
CK#:_____
RECD:_____
Scholarship:____

M / F

Last Name | First Name | # Seasons | Uniform Size

Address | City | Zip | DOB | Verified

"My child was _____ yrs. old on July 31, 20_____ and is in the _____ grade."

Parent 1:_____
Name | Contact Number | Email

Parent 2:_____
Name | Contact Number | Email

This program is made possible through volunteer efforts. Please choose how you would like to help. Thanks.
(Circle all that apply to you)

Head Coach	Team Parent	Concession	Fundraising
Assistant Coach	Team Sponsor	Field Assistance	Coordinator

Medical Conditions:_____

Emergency Contact:_____

Doctor:_____

I, the parent/guardian of the registrant, a minor, agree that I and the registrant will abide by the rules of the HCASF, the membership organizations that govern the sport registered for, and sponsors. I recognize the possibility of physical injury when participating in a sport or fitness activity and will not place a claim on behalf of the registrant against HCASF, its membership organizations, employees, board members, sponsors, or owners of facilities or fields used.

CONSENT FOR MEDICAL TREATMENT: As parent/guardian of the above registrant, I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor or Dentistry. This care maybe given under whatever conditions are necessary to preserve life, limb, or wellbeing of my dependent.

Signature of Parent/Guardian:_____ Date:_____

Rev 1.1