TOWN OF GILA BEND
2024 YOUTH VOLLEYBALL PLAYER REGISTRATION FORM

PLAYER INFORMATION

Player Name:

Address: _____

City/State/Zip: _____

Email: _____

Date of Birth: _____

League Age on Oct 14th: _____ Gender: M or F

Youth / Adult Shirt Size: _____

Youth / Adult Shorts Size: _____

My child will play: (select one)

☐ **AGES 5-8**

Oct 14th – Nov 13th (Games are Monday & Wednesday)

$10 payable at Town Hall / $25 late registration

- Birth Certificate copy required
- Parental Code of Conduct required

☐ **AGES 9-13**

Oct 14th – Nov 13th (Games are Monday & Wednesday)

$10 payable at Town Hall / $25 late registration

- Birth Certificate copy required
- Parental Code of Conduct required

Please list Siblings here:

$10 Registration Dates:

October 14th - September 9th

$25 Late Registration Dates:

September 10th -September 13th

League Dates: October 14th – November 13th

PARENT INFORMATION

Parent #1	Parent #2
Name: _____	Name: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

LIABILITY RELEASE

In consideration of my child's acceptance in this program, I, the undersigned, intending to be legally bound, do herby, for myself, my heirs, my personal representatives and assigns, waive, release and forever discharge any and all rights and claims for damages I may have or may hereafter accrue to me against the Town of Gila Bend, or any sponsor, its or their officers, agents, representatives, successors and/or assigns or any other corporations or individuals associated with the Town of Gila Bend, for any damages, claims, injuries, or actions sustained or suffered in connection with my child's association or entry in or arising out of their participation in said event. If in doubt as to my child's physical condition to engage in this event I have been advised to seek the advice of a competent physical and to abide by this advice. I attest and verify that I have full knowledge of the event risks involved in this program and my child is physically fit and sufficiently healthy to participate in this program.

Parent signature _____ Date: _____

TOWN USE ONLY

AGE 5-8		AGE 9-13	
☐ $10 Fee paid	***Oct 14th – Sept 9th***	☐ $25 Late Fee Paid	***Sept 10th – Sept 13th***
☐ Copy of Birth Certificate submitted			
☐ Parental Code of Conduct signed/submitted			
☐ Team Name: _____			

Town of
GILA BEND

PARENTS' CODE OF CONDUCT

Player's Name: _____ Date: _____

I hereby pledge to provide positive support, care, and encouragement for my child participating in youth sports by following this Parents' Code of Conduct.

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 my personal desire to win.

I will insist that my child play in a safe and healthy environment.

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 Conduct.

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 from 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 adults.

I will do my very 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 will 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 promise to make a commitment to volunteer and assist my system when asked, making time whenever I can.

Parent Signature Date

TOWN OF GILA BEND
RECREATION – MEDICAL RELEASE FORM

LEAGUE: Youth Volleyball

PLAYER NAME:	**DATE OF BIRTH:**

Parent/Guardian Name: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Player Address: _____ City: _____ State: _____ Zip: _____

FAMILY PHYSICIAN INFORMATION

Physician Name: _____

Phone: _____

Hospital preference: _____

Address: _____

City/State/Zip: _____

EMERGENCY CONTACT INFORMATION
If parent or legal guardian cannot be reached

#1	**#2**
Name: _____	Name: _____
Cell Phone: _____	Cell Phone: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Relationship to player: _____	Relationship to player: _____

List any allergies/medical problems, including those requiring maintenance medication (i.e. Diabetic, Asthma, Seizure Disorder). The purpose of the information listed below is to ensure medical personnel have details of any medical concern that may interfere with or alter treatment. Use an additional sheet of paper if necessary, and attach to Medical Release Form.

Medical Diagnosis	**Medication**	**Dosage**	**Frequency of Dosage**

MEDICAL COVERAGE INFORMATION

Insurance Carrier: _____

Policy ID#: _____ Group ID#: _____

PARENT/LEGAL GUARDIAN AUTHORIZATION

Parent or Guardian Authorization:

In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by certified emergency personnel (i.e. EMT, First Respondent, E.R. Physician).

Parent signature _____ Date: _____