

2008-2009 MIDDLESEX RECREATION DEPARTMENT TRAVEL BASKETBALL REGISTRATION FORM

****PARENTS PLEASE READ****

This is a competitive program. Children are required to try out for the team, meaning he/she may not make the team. Teams will be a combined 5th & 6th and 7th & 8th team. The league that each team will play in will be announced as soon as possible. Other than league play, teams may also play in one holiday tournament and one spring tournament. Some leagues/tournaments have rules that state an AAU player or a child that plays on his/her school team may NOT participate in their league/tournament. You will be notified of any such rule as soon as possible. If your child makes the team please be aware that practices are at the coach's discretion and may be longer than a normal recreation practice. Children must be able to attend the try out date– no exceptions. If your child makes the team, payment (\$40) is due at the Recreation Department before the first scheduled practice. Checks can be made payable to "Middlesex Recreation Department". Try-outs are on Friday, October 24, 2008: 6:30PM – 8:00PM for 7th & 8th Grade Girls and 8PM-9:30PM for 7th & 8th Grade Boys and on Saturday, October 25, 2008: 9AM-10:30AM for 5th & 6th Grade Girls and 10:30AM – Noon for 5th & 6th Grade Boys. All try outs will be held in the Middlesex High School Gym.

DEADLINE TO REGISTER IS FRIDAY, OCTOBER 17, 2008 BY 4:00PM. IF YOU DO NOT REGISTER BY THIS TIME - YOU MAY NOT ATTEND AND/OR REGISTER AT TRY OUTS – NO EXCEPTIONS WILL BE MADE.

Check one:

Girls 5th & 6th _____ Girls 7th & 8th _____
Boys 5th & 6th _____ Boys 7th & 8th _____

DO NOT write in box / for office use only

\$40 Reg. Fee Pd. _____ (due after try outs)

Receipt # _____

RCV'D _____

NAME (print *CLEARLY*) _____ DOB: ____/____/____ GRADE _____

ADDRESS _____ HOME PHONE _____

EMERGENCY TREATMENT RELEASE

Dates during which release is granted: From: October 31, 2008 To: March 31, 2009

TO WHOM IT MAY CONCERN: As a parent and/or guardian of _____, a minor, I herewith authorize the treatment by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Parent (s)/Guardian Info:

Mothers Name _____ address (if different than above) _____ Ph # _____ Cell # _____

Fathers Name _____ address (if different than above) _____ Ph # _____ Cell # _____

Mother's e-mail _____ Father's e-mail _____

Other contact in case of emergency (DO NOT USE YOURSELF): Name _____

Phone _____ H / W / C Relationship to child _____ Hospital Preference _____

Specific medical allergies, chronic illness or other medical conditions the staff should be aware of: _____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence. I confirm that my child is up to date on all immunizations as required by the NJ Dept. of Health and Senior Services Annual Immunizations Report. I also agree that all the information provided is correct and factual. If information is found to be false, I understand that my child will be expelled from the program without reimbursement of fees paid.

Parent/Guardian Signature _____ Date: _____