



PLAYER REGISTRATION FORM - 3RD GRADE

2010 - 11

LEMONT PARK DISTRICT BASKETBALL LEAGUE

CIRCLE ONE

NAME _____ MALE FEMALE

AGE: _____ DATE OF BIRTH _____

SCHOOL _____

PARENT'S NAME _____

HOME PHONE # () _____ CELL # () _____

EMERGENCY PHONE # _____

EMERGENCY PHONE # _____

E-MAIL _____

PREVIOUS EXPERIENCE _____

COMMENTS (LIST ANY CONFLICTS) _____

ANYTHING ELSE YOU'D LIKE TO TELL ABOUT YOURSELF

UNIFORM SIZE: _____ (Youth S, M, L; Addult S, M, L, XL)
(includes top and shorts) (e.g. Y M = youth medium; AM = adult medium)
(No different size for top & bottom)

UNIFORM
Requested _____
1st choice 2nd choice 3rd choice

RETURN THIS ENTIRE PACKET TO THE LEMONT PARK DISTRICT

Lemont Park District's Basketball League Medical Form

Please fill out completely.

****Important: Your child will not be permitted to play without this completed form.
There will be no exceptions.****

Child's Name _____

Home Address _____

Home phone number: () _____ - _____

Name of person who will be dropping off _____ / _____
Relation

Name of person who will be picking up _____ / _____
Relation

Parents' names: _____
Mother Father

Parents' work #'s () _____ () _____
Mother Father

Please provide any other forms of communication that you use so that we may contact you in case of emergency: *Cell phone* _____ *Pager* _____

Physicians' name: _____

Physicians' phone #: () _____

Please list any serious illness or operations your child has had, include this year:

Is your child presently taking medicines? _____ _____
yes no

If yes, please fill in:

Medication name Dosage Time last taken

****Medication will not be given to any child unless a note is given to the day camp instructors written & signed by the child's doctor.

Date of last tetanus shot (year): _____

Does your child have any allergies to medication, insect bites, foods, etc? Please list:

*******ONLY FILL OUT & RETURN IF CHILD HAS TO SELF-ADMINISTER MEDICINE*******
LEMONT PARK DISTRICT MEDICAL AUTHORIZATION FORM
PHYSICIAN'S ORDER MEDICATION DURING LPD BASKETBALL LEAGUE

PLAYER'S NAME _____ D/O/B _____ GRADE _____

ADDRESS _____ CITY/STATE _____

I HAVE DETERMINED THAT THE FOLLOWING MEDICATION IS NECESSARY FOR THE CRITICAL HEALTH AND WELL BEING OF THE PLAYER AND MUST, THEREFORE, BE SELF-ADMINISTERED BY THE PLAYER UNDER SUPERVISION.

MEDICATION _____ ROUTE _____

DOSAGE _____ FREQUENCY _____ TIME GIVEN _____

THE MEDICATION MAY BE SELF-ADMINISTERED UNDER SUPERVISION. _____
Y N

DIAGNOSIS _____

INTENDED EFFECT OF MEDICATION _____

SIDE EFFECTS TO WATCH FOR _____

RE-EVALUATION DATE _____ DISCONTINUATION DATE _____

OTHER MEDICATIONS CAMPER/STUDENT IS TAKING _____

Physician's signature Physician's name (typed)

() _____
Telephone # Date

PARENT'S REQUEST FOR SELF-MEDICATION

I REQUEST THAT A DESIGNATED EMPLOYEE OF THE LEMONT PARK DISTRICT BE ASSIGNED TO SUPERVISE MY CHILD WHILE SELF-ADMINISTERING THE MEDICATION AS PER PHYSICIAN'S ORDER.

Prescription # Pharmacy and Phone #

I CAN BE REACHED AT THE FOLLOWING NUMBER/S IN CASE THERE IS A PROBLEM:

() _____ () _____

Parent/Guardian Signature Supervisor/Employee's Signature Date