BROTHERHOOD CRUSADE YOUTH SPORTS LEAGUE
P.O. BOX 94180, PASADENA, CA 91109
PHONE/FAX # 626-797-5673 www.bhcsports.org

MUNCHKIN REGISTRATION

Program:_____ **Date**_____ **DOB:** _____

Child's Name: _____ _____ _____
First **MI** **Last**

Address:_____ **City** _____ **Zip** _____

Age:_____ **Sex:** _____

Parent/Guardian Name: _____ **Phone:** _____

Cell:_____ **Email address:** _____

Emergency Contact:_____ **Phone** _____
Must be different than above #'s

Relationship to Parents:_____

Would you like to volunteer ? **Yes** **No** **Would you like to coach?** **Yes** **No**

AUTHORIZATION FOR TREATMENT OF A MINOR

I, the undersigned, as parent/legal guardian of the above minor hereby authorize the BROTHERHOOD CRUSADE YOUTH SPORTS LEAGUE or the delegated representative to consent to medical or dental treatment and/or hospital care to be rendered to said minor upon the advice of a licensed physician or dentist. This authorization is pursuant to the provisions of Section 25.8 of the Civil Code of California and California Practices Act. It is understood that if time and circumstances permit, the BROTHERHOOD CRUSADE YOUTH SPORTS LEAGUE, will endeavor, but it is not required to communicate with me prior to such treatment. NO REFUNDS OR CREDIT **PARENTS: YOU MUST REMAIN WITH YOUR CHILD AT ALL TIMES.**

EMERGENCY TREATMENT AND TRANSPORTATION AUTHORIZATION

Policy/Medical number for insured_____**for Child** _____

Insurance/Medical Company_____

Insured's Employer_____**Employee's Phone** _____

Physician _____**Phone** _____

I have read this release. Signature _____**Date**_____