



Southern Tier Challenger League
516 Front St., Vestal NY 13850
607-754-3368



Note: This form must be carried along with the roster at every game.

Application to Play

Player: (First) _____ (Last) _____

Date of Birth: _____ Team Name: _____

Parent/Guardian: (First) _____ (Last) _____

Phone: (h) _____ (c) _____

Parent/Guardian: (First) _____ (Last) _____

Phone: (h) _____ (c) _____

Parent or Guardian Authorization:

In case of an emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Personnel (i.e. EMT, First Responder, ER Physician)

Family Physician: _____ Phone: _____

Address: _____

Hospital Preference: _____

If a parent or legal guardian cannot be reached in case of an emergency, please contact:

Name	Phone	Relationship

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Please list any allergies/medical problems, including those requiring maintenance medication (i.e. Diabetic, Asthma, Seizure Disorder...)

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

Date of last Tetanus Booster: _____

The purpose of the above listed information is to ensure that medical personnel have details to any medical problem which may interfere with or alter treatment.

Parent/Guardian signature: _____ **Date:** _____

Warning: Protective equipment cannot prevent all injuries a player might receive while participating in Baseball.

Southern Tier Challenger League does not limit participation in this league on the basis of disability, race, color, creed, national origin, gender or religious preference.