BLAINE YOUTH LACROSSE

BOYS SPRING TEAM 2012

Registration is now taking place for a Boys Spring 5/6 Team and 7/8 Team. Space is limited to the first 20 kids to sign up (for each team). This is a developmental league and is open to new and experienced players. **We will allow 4th grade players if room permits.**

Participants are required to be members of US Lacrosse. Members will receive comprehensive insurance coverage, lacrosse magazines, plus other benefits. To become a member and to learn more, register online at www.uslacrosse.org. The youth membership fee is $25 and is paid directly to USL in addition to the Blaine Lacrosse Association participation fee of **$100.00.**

ALL players need to **have a current US Lacrosse membership as of March 2012.**
If your player's number expires some time during this season, you will still need to renew in March 2012, before the season starts. ALL players must show proof of lacrosse number and expiration date on this registration form.

MAIL REGISTRATION: Mail registration from and payment of $100.00 along with your US Lacrosse membership number and expiration date to:
Blaine Youth Lacrosse
4335 Pheasant Ridge Dr. NE
Suite 224-PMB 121
Blaine, MN 55449

Registrations must be postmarked by **Monday, February 27, 2012**.
Make checks payable to: **Blaine Youth Lacrosse**

2012 Blaine Youth Lacrosse
Offered by Blaine Youth Lacrosse 4335 Pheasant Ridge Dr NE Suite 224-PMB 121, Blaine, MN 55449

Date ______________________________ School & Grade May 2012 _______________

Name ______________________________ New or previous player (circle one)

Address ____________________________ US Lacrosse member #______ Exp. date_______

City & Zip ___________________________ Position: _______________________________

Parents/Guardians Name____

Email ____

Home Phone# ____

Cell Phone(s)# ____

Work Phone# ____

I am willing to volunteer as: Asst. Coach Team Manager Time Keeper (Circle all that apply)
All volunteer coaches and assistant coaches will need to submit to a confidential background check with The Blaine Youth Lacrosse Association. Players will be placed on a team based on grade at time of registration.

PLEASE COMPLETE BOTH SIDES OF FORM

Questions:
Wendy Johnson (President & Spring Coordinator)
Phone: 763-767-8738
Email: johnsonwa3@aol.com

***Required personal equipment:** Full gear must be worn for all practices and games. Full gear consists of a lacrosse helmet **(no hockey helmets),** mouth guard (not clear or white), shoulder & elbow pads, athletic cup/pelvic protector, stick, and lacrosse gloves. Additional gear for goalie will be supplied by the association.

*Dave's Sport Shop in Fridley & Blaine, and Play It Again are good sources for lacrosse equipment.

Health Consent & Release Form

Participant's Name________________________ Birth Date___________

Recognizing the possibility of physical injury associated with the sport of lacrosse, I hereby release, discharge and or otherwise indemnify the Blaine Lacrosse Association, its affiliate associations, member teams, event hosts and each of them and their directors, officers, employees, operators, trustees, members and agents against and from any and all claims, expenses, costs, damages, loss, accidents, fines, judgments, awards, liabilities and causes of action as a result of the registrant's participation in the sport of lacrosse. I assume all risks associated with participation in the sport of lacrosse. I assume all risks associated with participation in this sport, including but not limited to falls, contact with other participants, the effects of weather, traffic, and other reasonable risk conditions associated with the sport of lacrosse. All such risks to my child are known and understood by me.

Parent/Guardian Signature________________________________ Date___________

Player Signature____ Date___________

Consent for Medical Treatment:
As a parent or legal guardian of the player listed above, I hereby give my consent to Blaine Lacrosse Association to provide emergency medical treatment of an injury or illness of my child if qualified medical or dental personnel consider treatment necessary and perform the treatment. This authorization is granted only if I cannot be reached and a reasonable effort has been made to do so.

Parent/Guardian Name (PRINT) ______________________ Date_____________
Parent/Guardian Signature___________________________ Date_____________
Cell Phone________________ Work Phone______________ Home Phone _____________
Health Care Provider__________________________________ Policy#_______________
Physician______________________________________ Phone#_______________
Dentist _______________________________________ Phone#_______________
Pre-existing medical condition (allergies, medications or chronic illness)

Other Contact in case of emergency_______________________ Phone#_____________