

BASEBALL ACADEMY OF HAWAII

REGISTRATION FORM

PLAYER INFORMATION	
(PLEASE PRINT CLEARLY)	
FIRST NAME	LAST NAME
BIRTHDATE	EMAIL ADDRESS:
PARENT(S)/LEGAL GUARDIAN INFORMATION	
FATHER/LEGAL GUARDIAN NAME	MOTHER/LEGAL GUARDIAN NAME
PARENT HOME PHONE / CELL	PARENT HOME PHONE / CELL
MAILING ADDRESS	CITY, STATE ZIP
EMAIL ADDRESS	
EMERGENCY AND MEDICAL INFORMATION	
IN CASE OF EMERGENCY CONTACT:	EMERGENCY PHONE #
INSURANCE COMPANY	MEDICAL INSURANCE CARD POLICY #
MEDICAL CONDITIONS	KNOWN ALLERGIES

Please Write Checks out to:

Baseball Academy of Hawaii
1410 Lekeona Street
Kailua, HI 967344

**Assumption of Risk/Medical Release Form
Baseball Academy of Hawaii**

Name of Child: _____
(Last Name, First Name, Middle Initial)

I, the undersigned, certify that the above child is in good physical health and is able to participate in the **Baseball Academy of Hawaii Clinics**. I, also understand and acknowledge dangers and risks involved with my child's participation in the clinic which include, but are not limited to: minor injuries such as bruises, lacerations, strains, and sprains, over exertion injuries (such as heat stroke, cardiac arrest or respiratory arrest), broken bones or dislocations or the possibility of permanent disability and death, as well as property loss and severe social and economic loss. The dangers and risks may be caused by, but are not limited to: (a) the actions, omissions or negligence of the instructors, sponsors, participants, volunteers, spectators; (b) conditions of the premises and/or equipment used; (c) temperature and/or weather; (d) conditions of other participants.

I understand that my child should have his/her own private medical and liability insurance coverage if he/she intend to participate in the clinic, and that the Baseball Academy of Hawai'i does not provide insurance for my child and will not be financially responsible for my child or indemnify my child with respect to injuries or liabilities arising out of my child's participation in the clinic.

I authorize Baseball Academy of Hawaii and its staff, coaches or agents to refer said minor player, if injured or ill, to any licensed physician, hospital, or dental clinic or office it deems necessary when I or my spouse cannot be reached, in which case they shall be deemed as my agents to consent to medical, surgical and/or dental examination and/or treatment. I also consent to, and authorize any medical professional and others working under their supervision to treat my child for any injury or illness arising from or related to my child's participation in the clinic, and agree to pay any and all medical expenses, costs and other charges, and to indemnify, release and discharge the Hawaii Baseball Academy, and its officers, employees, agents and assigns from any and all liability, claims, demands or actions arising from or connected with such medical treatment or care.

The clinic may attract media coverage. My child may be photographed and/or videotaped while participating in the clinic, and the photograph and/or video tape may appear in print media and/or live or replay telecast. I therefore grant my permission for my child to be photographed and/or appear in a telecast of the clinic if my child participates in the clinic.

In consideration of my child being permitted to participate in the clinic, I agree to assume all risks of injury and loss resulting from my child's participation in the clinic. I read and understand all written materials setting forth the requirements for my child's participation, and understood all oral instructions, and my child will strictly observe them during his/her participation. Most importantly, for myself, my heirs, executors, and administrators, I accept full responsibility for my child's participation in the clinic and I agree to indemnify, release and discharge the Hawaii Baseball Academy of Hawaii, and its officers, employees, coaches, & volunteers and assigns from any and all liability, claims, demands or actions for property damage, personal injury and/or death arising or resulting from or caused by any acts or omissions by child or others during my participation in the clinic.

I am aware that this contract is legally binding and that I am releasing legal rights by signing it. I have read this release and by signing below I agree to all of its provisions.

Signature of Parent(s)/Guardian(s) Date

Printed Name(s)