# HOBSON WEST WATER POLO REGISTRATION

| | |
|---|---|
| LAST NAME | |
| FATHER'S NAME | MOTHER'S NAME |
| ADDRESS | |
| TELEPHONE HOME | |
| FATHER'S WORK | |
| MOTHER'S WORK | |
| MOTHER'S CELL | |
| OTHER | |
| EMAIL ADDRESS | |

| Player's Name | Birth date | Age as of 5/31 | M/F | Allergies |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

EMERGENCY CONTACT:_____

SWIMMER'S PHYSICIAN:_____

SIGNIFICANT MEDICAL HISTORY_____

_____

LAST TETANUS SHOT:_____

I, the undersigned, hereby grant permission for the Hobson West Water Polo team coaching staff and/or parent volunteers to obtain and authorize any emergency medical treatment deemed necessary by the examining physician.

_____ _____

(signature) (relationship) (date)

I, the undersigned, give the Hobson West Waves Water Polo Team, the absolute right and permission to use unidentified photograph(s) of my child(ren) in the members-only section of the Waves website and first name only picture and identity on the Water Polo bulletin board at the Hobson West Clubhouse.

_____ _____

(signature) (relationship) (date)