

CITY OF LOS ANGELES DEPARTMENT OF RECREATION AND PARKS

SPORTS:	
TEAM:	
DIVISION:	



FEE PAID:	
RR NUMBER:	
RECEIVED BY:	

PECAN RECREATION CENTER

PLAYER INFORMATION

LAST NAME:		FIRST NAME:		MIDDLE INITIAL:
BIRTH DATE: / /		AGE:		GENDER: <input type="checkbox"/> M <input type="checkbox"/> F
SCHOOL:		GRADE:	RETURNING PLAYER: <input type="checkbox"/> YES <input type="checkbox"/> NO	
ADDRESS:			APT #:	
CITY:			ZIP CODE:	

MEDICAL PROBLEMS OR SPECIAL NEEDS:

PARENT INFORMATION

PARENT/GUARDIAN #1:	
CELL PHONE:	HOME NUMBER:
PARENT/GUARDIAN #2:	
CELL PHONE:	HOME NUMBER:
EMERGENCY CONTACT:	RELATIONSHIP:
CELL NUMBER:	HOME NUMBER:

PLEASE CHECK IF INTERESTED IN THE FOLLOWING: COACH ASSISTANT COACH VOLUNTEER

PARENT CONSENT FORM

I, the undersigned, give permission for my child, whose name appears above, to attend and participate in the athletic program. I understand that my child may be transported to and from the event and that the nature of this event is a sports activity. I know my minors experience and capabilities and believe the minor to be qualified, in good health, and in proper physical condition to participate in such activity. I agree to relieve the City of Los Angeles Department of Recreation and Parks, its officer agents and employees from any liability in connection with any injury to my child in connection with this activity. I understand that the City and Recreation Facility CARRY NO INSURANCE.

Right of Publicity: I authorize the city of Los Angeles Department of Recreation and Parks to make, procure, or use photographs, film, tapes or other likenesses or Minor's physical image and/or voice as may be needed for use with the programs publicity material in perpetuity without compensation.

I, the undersigned parent of, _____ a minor, do hereby authorize the City of Los Angeles, Department of Recreation and Parks as agents for the under-signed to consent to X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or specialized supervision of any physician licensed under the provisions of the Medical Practice Act on the staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or a said hospital. It is understood that this authorization is given in advance of any such diagnosis, treatment or hospital care, which the aforementioned physician in the exercise of his best judgment may deem advisable. This authorization shall remain effective for the duration of the program, unless revoked sooner in writing and delivered to said agent.

PARENT SIGNATURE: _____ **DATE:** _____

CITY OF LOS ANGELES DEPARTMENT OF RECREATION AND PARKS

DEPORTE:	
EQUIPO:	
DIVISION:	



FEE PAID:	
RR NUMBER:	
RECEIVED BY:	

PECAN RECREATION CENTER

INFORMACION DE JUGADOR

APELLIDO:		NOMBRE:		INICIAL:	
FECHA DE NACIMIENTO: / /		EDAD:		GENERO: <input type="checkbox"/> M <input type="checkbox"/> F	
ESCUELA:		GRADO:		RETURNING PLAYER: <input type="checkbox"/> YES <input type="checkbox"/> NO	
DOMICILIO:			APT #:		
CIUDAD:			ZONA POSTAL:		
NECESIDADES MEDICAS:					

INFORMACION DE PADRE

PADRE/GUARDIAN #1:					
CELULAR:			NUMERO DE CASA:		
PADRE/GUARDIAN #2:					
CELULAR:			NUMERO DE CASA:		
CONTACTO DE EMERGENCIA:				RELACCION:	
CELULAR:			NUMERO DE CASA:		
ESTOY INTERESADO/A EN SER: <input type="checkbox"/> ENTRENADOR <input type="checkbox"/> AYUDANTE DE EQUIPO <input type="checkbox"/> VOLUNTARIO					

FORMA DE CONSENTIMIENTO

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FIRMA DE PADRE:	FECHA:
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