



HH CODE:

City of Los Angeles Department of Recreation & Parks

ROSE HILL RECREATION CENTER

Good Sportsmanship is Everyone's Responsibility...Be a Good Sport!

SPORT/CLASS:	DIVISION:
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P L A Y E R	Last Name:	First Name:	Gender:
	Birthdate: / /	School:	Age:
	Are you a returning player? Yes No	If yes, which team:	
	Address:	City:	Zip Code:
	Phone: ()	Cell Phone: ()	Email:
	Emergency Contact:	Relationship:	
	Phone: ()	Cell Phone: ()	Email:
	Team Name:	Manager's Name:	

How did you hear about us:

Please circle if you are interested in the following: **COACH** **ASSISTANT COACH** **VOLUNTEER**

CONSENT FORM

I, the undersigned, agree to attend and participate in the athletic program. I understand that I may be transported to and from the event and that the nature of this event is a sports activity. I know my experience and capabilities and believe 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 myself 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 of my physical image and/or voice as may be needed for use with the programs publicity material in perpetuity without compensation.

I, the undersigned, _____, 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.

Signature: _____ **Date:** / /

RULES

I promise to demonstrate good sportsmanship, in both victory and defeat and to follow all said league rules. I further understand that all fees are due at the beginning of hte season, and that once play has begun there are not refunds. A 20% REFUND FEE MAY BE CHARGED BEFORE PLAY HAS BEGUN.

Signature: _____ **Date:** / /

MINOR'S 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's Name: _____ **Signature:** _____ **Date:** / /

****FOR STAFF USE ONLY****

RR #:	AMOUNT: \$	RECEIVED BY (Initial):	AGE VERIFIED (Initial):
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