Illinois Hoop Dreams
2019 Registration Application

- The completed application and registration due at time of tryouts.
- No refund will be granted to any individual once the player is rostered and fee paid.
- Season fees TBA at tryouts.

Last Name: ____________________________ First Name: ___________________________

Current Grade:______Birthdate:_____/_____/_____High School Grad Date: 20_______

Address:____

City:______________________________State:_________________Zip:______________

Parent/Guardian Name:____

Home Phone:________________________ Work Phone:____________________________

Cell Phone 1:________________________ Cell Phone 2:____________________________

Email 1:______________________________Email 2:______________________________

Emergency Contact:________________________ Emergency Phone:____________________

ONLY COMPLETE IF NEW UNIFORM IS REQUIRED

Uniforms: (Women's jerseys / Men's shorts)

Jersey Size: ___ S ___M ___L ___ XL____XXL

Short Size: ___ S ___M ___L ___ XL____XXL

Shirt Size: ___ S ___M ___L ___ XL____XXL

Uniform Number Preference: (we can't guarantee you will get your first choice but we will try)

1st Choice________, 2nd ________, 3rd________, 4th__________

I give consent for my daughter to be photographed, videotaped or filmed while participating in IHD AAU activities and for the resulting photos to be used by Illinois Hoop Dreams Basketball Club and/or AAU for educational and/or promotional purposes. I have read and understand the above.

Parent/Guardian Signature ____ Date_______

Medical Release Form

NAME OF Participant: ___________________________AGE AS OF March 1st, 2019:________

MEDICATION OR ALLERGIES: ____

MEDICAL CONCERNS
(PLEASE ADVISE):____

DATE OF LAST TETANUS: ____________PARENTS NAME(S):________________________

ADDRESS: _____________________________CITY:____________________STATE:______

HOME PHONE: ____________________CELL PHONE/PAGER: ________________________

FAMILY DOCTOR: ____

DOCTOR'S PHONE: ____

IN THE EVENT OF EMERGENCY AND I AM NOT AVAILABLE PLEASE CONTACT:

NAME: ______________________________________RELATIONSHIP:_____________________

BEST PHONE TO REACH: _________________________CELL/PAGER: ___________________

INSURANCE COMPANY ____________________________ POLICY # _____________________

**** Note: Release must be signed by parent or guardian

AUTHORIZATION FOR MEDICAL TREATMENT

In the event of an emergency medical situation relating to my minor child listed below, and in the event that I am unavailable, I hereby give my permission/consent to the nearest medical center or any emergency treatment center or hospital to administer whatever emergency medical care deemed appropriate by that emergency medical staff until I can be contacted.

I hereby authorize the directors and staff of Illinois Hoop Dreams to act for me according to their best judgment in any emergency requiring medical attention. I hereby waive and release Illinois Hoop Dreams Directors, Coaches, Counselors, Staff, the facilities for liabilities relating to injury, illness, or expense incurred while participating in this program. I know of no mental or physical problems, which might affect my child's ability to safely participate in this program. I realize the inherent risks involved in the program and appreciate the nature of the risks. Individuals registered for this program are encouraged to seek a physician's approval. I will be responsible for any medical or other charges in connection with my child's participation with the Illinois Hoop Dreams Basketball Club.

PARENT SIGNATURE: ____ DATE: ______________