Southwest Louisiana USSSA

2017 SPRING SEASON PLAYER REGISTRATION

PO Box 6632
Lake Charles, LA 70606
www.SWLAUSSSA.com info@swlausssa.com

Submit all of the following items:

1) Completed Form
2) Copy of Birth Certificate
3) Registration Fee

Make checks payable to SWLA USSSA

Spring 2017 Registration - $65 per child

$350 Sponsor Fee

Deadline to register: February 11, 2017

PRE-FORMED TEAMS MAY ENTER in 6/u & 4/u

Players Last Name	Players First Name	Middle Initial

Mailing Address	City	Zip Code

Mother or Guardian's Name	E-Mail Address
Father or Guardian's Name	**E-Mail Address**

Home Phone Number	Cell Phone Number	Alt. Phone Number

Players Date of Birth – MM/DD/YY	Male/Female	Circle One: 1) Returning Player 2) New Player	What League did Player play in last season:

Age group eligibility of child is based on the age of the child on May 1, 2017

PLEASE CHECK OFF SPORT/AGE GROUP BELOW

BOYS BASEBALL

	Co-Ed Baseball - Wee Ball – 4/u		Boys Baseball – 11/u
	Co-Ed Baseball – T-Ball – 6/u		Boys Baseball – 14/u
	Boys Baseball – Coach Pitch – 8/u		Boys Baseball – 18/u

Parental (Adult) Support: Please check a box and participate in our youth program.

_____ Team Manager _____ Assistant Coach _____ Team Parent _____ Team Sponsor ($350)

I, the parent/guardian of the registrant, a minor, agree that myself and the registrant will abide by all rules of the Southwest Louisiana USSSA. In recognizing the possibility of injuries associated with baseball, I hereby release, and or otherwise indemnify the Southwest Louisiana USSSA, all of its' affiliated organizations, their sponsors, employees and associated people against any claim by or on behalf of the registrant as a result of the registrant's participation in the programs and being transported to or from the game. I also understand that there is an additional Sponsor Fee of $350 per team. If a Sponsor is not found, then the fee is divided amongst the players.

CONSENT FOR MEDICAL TREATMENT TO A (MINOR)

As the parent or the legal guardian of the above named player, I hereby give my consent for EMERGENCY MEDICAL CARE prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life or well-being of my dependent.

BY: PRINT _____ SIGNATURE _____ DATE _____

OFFICE USE ONLY

PAYMENT AMOUNT: PAYMENT METHOD: DATE: RECEIVED BY: