



## REGISTRATION FORM

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Age

\_\_\_\_\_  
Birthdate

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Email

\_\_\_\_\_  
Referral Description (if any)

\_\_\_\_\_  
Emergency Contact Name

\_\_\_\_\_  
Emergency Contact Home Phone

\_\_\_\_\_  
Emergency Contact Daytime Phone

\_\_\_\_\_  
Operations or serious Injuries (with dates)

\_\_\_\_\_  
Disabilities - chronic or recurring illness

\_\_\_\_\_  
Any activities to be limited by doctor's advice

\_\_\_\_\_  
Current Medications

\_\_\_\_\_  
Allergies

Do you now play in a league?  MSBL  NABA  Other \_\_\_\_\_ If yes, for how long? \_\_\_\_\_

If No, when was the first time you played baseball? \_\_\_\_\_

Field Position: 1st Choice: \_\_\_\_\_ 2nd Choice: \_\_\_\_\_

Bats:  Right  Left Throws:  Right  Left

Hotel Reservation:  Single  Double

What do you most want to learn from this clinic?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_