



**PLAYER REGISTRATION FORM - 4<sup>TH</sup> GRADE**

2009-10

**LEMONT PARK DISTRICT BASKETBALL LEAGUE**

CIRCLE ONE

NAME \_\_\_\_\_ MALE FEMALE

AGE: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SCHOOL \_\_\_\_\_

PARENT'S NAME \_\_\_\_\_

HOME PHONE # ( ) \_\_\_\_\_ CELL # ( ) \_\_\_\_\_

EMERGENCY PHONE # \_\_\_\_\_

EMERGENCY PHONE # \_\_\_\_\_

E-MAIL \_\_\_\_\_

PREVIOUS EXPERIENCE \_\_\_\_\_

\_\_\_\_\_

COMMENTS (LIST ANY CONFLICTS) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ANYTHING ELSE YOU'D LIKE TO TELL ABOUT YOURSELF

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

UNIFORM SIZE: \_\_\_\_\_ (Youth S, M, L; Adult S, M, L, XL)  
(includes top and shorts) (e.g. Y M = youth medium; AM = adult medium)  
**(No different size for top & bottom)**

**UNIFORM**  
# Requested \_\_\_\_\_  
1<sup>st</sup> choice                      2<sup>nd</sup> choice                      3<sup>rd</sup> choice

**RETURN THIS ENTIRE PACKET TO THE LEMONT PARK DISTRICT**

# Lemont Park District's Basketball League Medical Form

*Please fill out completely.*

**\*\*Important: Your child will not be permitted to play without this completed form.  
There will be no exceptions.\*\***

Child's Name \_\_\_\_\_

Home Address \_\_\_\_\_

\_\_\_\_\_

Home phone number: (      ) \_\_\_\_\_ - \_\_\_\_\_

Name of person who will be dropping off \_\_\_\_\_ / \_\_\_\_\_  
Relation

Name of person who will be picking up \_\_\_\_\_ / \_\_\_\_\_  
Relation

Parents' names: \_\_\_\_\_  
Mother Father

Parents' work #'s (      ) \_\_\_\_\_ (      ) \_\_\_\_\_  
Mother Father

Please provide any other forms of communication that you use so that we may contact you in case of emergency: *Cell phone* \_\_\_\_\_ *Pager* \_\_\_\_\_

Physicians' name: \_\_\_\_\_

Physicians' phone #: (      ) \_\_\_\_\_

Please list any serious illness or operations your child has had, include this year:

\_\_\_\_\_  
\_\_\_\_\_

Is your child presently taking medicines?      \_\_\_\_\_      \_\_\_\_\_  
yes      no

If yes, please fill in:

Medication name      Dosage      Time last taken

\*\*\*\*Medication will not be given to any child unless a note is given to the day camp instructors written & signed by the child's doctor.

Date of last tetanus shot (year): \_\_\_\_\_

Does your child have any allergies to medication, insect bites, foods, etc? Please list:

\_\_\_\_\_  
\_\_\_\_\_

**\*\*\*\*\*ONLY FILL OUT & RETURN IF CHILD HAS TO SELF-ADMINISTER MEDICINE\*\*\*\*\***  
**LEMONT PARK DISTRICT MEDICAL AUTHORIZATION FORM**  
**PHYSICIAN'S ORDER MEDICATION DURING LPD BASKETBALL LEAGUE**

PLAYER'S NAME \_\_\_\_\_ D/O/B \_\_\_\_\_ GRADE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY/STATE \_\_\_\_\_

I HAVE DETERMINED THAT THE FOLLOWING MEDICATION IS NECESSARY FOR THE CRITICAL HEALTH AND WELL BEING OF THE PLAYER AND MUST, THEREFORE, BE SELF-ADMINISTERED BY THE PLAYER UNDER SUPERVISION.

MEDICATION \_\_\_\_\_ ROUTE \_\_\_\_\_

DOSAGE \_\_\_\_\_ FREQUENCY \_\_\_\_\_ TIME GIVEN \_\_\_\_\_

THE MEDICATION MAY BE SELF-ADMINISTERED UNDER SUPERVISION. \_\_\_\_\_  
Y N

DIAGNOSIS \_\_\_\_\_

INTENDED EFFECT OF MEDICATION \_\_\_\_\_

SIDE EFFECTS TO WATCH FOR \_\_\_\_\_

RE-EVALUATION DATE \_\_\_\_\_ DISCONTINUATION DATE \_\_\_\_\_

OTHER MEDICATIONS CAMPER/STUDENT IS TAKING \_\_\_\_\_

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Physician's name (typed)

( ) \_\_\_\_\_  
Telephone #

\_\_\_\_\_  
Date

**PARENT'S REQUEST FOR SELF-MEDICATION**

I REQUEST THAT A DESIGNATED EMPLOYEE OF THE LEMONT PARK DISTRICT BE ASSIGNED TO SUPERVISE MY CHILD WHILE SELF-ADMINISTERING THE MEDICATION AS PER PHYSICIAN'S ORDER.

\_\_\_\_\_  
Prescription #

\_\_\_\_\_  
Pharmacy and Phone #

I CAN BE REACHED AT THE FOLLOWING NUMBER/S IN CASE THERE IS A PROBLEM:

( ) \_\_\_\_\_ ( ) \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Supervisor/Employee's Signature

\_\_\_\_\_  
Date