2016 2017

All Saints CYO registration fees are $40 per child or a maximum of $70 per family. * A $20 fee will be assessed for any late registrations.

Player Information (Please Print)

Name: ______________________ Date of Birth: ______________

Address: ______________________ Age: ______________

Parish: ______________________ Grade: ______________

Parent / Guardian Information (Please Print)

Primary Contact		Emergency Contact	
Name:	______________	Name:	______________
Address:	______________	Address:	______________
City,State, Zip:	______________	City,State, Zip:	______________
Home Phone:	______________	Home Phone:	______________
Mobil Phone:	______________	Mobil Phone:	______________
Email Address:	______________	Email Address:	______________

Other Siblings Playing All Saints Basketball (Please Print)

Name	Age	DOB	Grade

COACHING

I am interested in volunteering my time to coaching a team at All Saints this year.

Name: ______________________________

Contact Number: ______________________________

(Please turn over)

Please place a "X" next to any health issue your child may have so that our coaches can be sensitive to the athlete's needs. Please complete this list for each child that will be registered in the program.

CHILD 1 NAME: ______________________________

	YES	NO
Allergies	________	________
Bee Sting Allergy	________	________
Asthma	________	________
Anemia	________	________
Convulsions/Seizures	________	________
Fainting	________	________
Ear problems/Hearing Loss	________	________
Headaches	________	________
Head Injury	________	________
Heart Conditions	________	________
Nose Bleeds	________	________
Ankle Problems	________	________
Back Problems	________	________
Knee Problems	________	________
Neck Problems	________	________
Wear Glasses/Contacts	________	________

CHILD 2 NAME: ______________________________

	YES	NO
Allergies	________	________
Bee Sting Allergy	________	________
Asthma	________	________
Anemia	________	________
Convulsions/Seizures	________	________
Fainting	________	________
Ear problems/Hearing Loss	________	________
Headaches	________	________
Head Injury	________	________
Heart Conditions	________	________
Nose Bleeds	________	________
Ankle Problems	________	________
Back Problems	________	________
Knee Problems	________	________
Neck Problems	________	________
Wear Glasses/Contacts	________	________

CHILD 3 NAME: ______________________________

	YES	NO
Allergies	________	________
Bee Sting Allergy	________	________
Asthma	________	________
Anemia	________	________
Convulsions/Seizures	________	________
Fainting	________	________
Ear problems/Hearing Loss	________	________
Headaches	________	________
Head Injury	________	________
Heart Conditions	________	________
Nose Bleeds	________	________
Ankle Problems	________	________
Back Problems	________	________
Knee Problems	________	________
Neck Problems	________	________
Wear Glasses/Contacts	________	________