Player Registration

____
Player Name

____
Parent/Guardian Name(s)

____
Street Address

____
City

____
State Zip

____
Player's E-mail Address

____
Parent/Guardian E-mail Address

Home Phone ___________________________

Cell Phone ___________________________

Player's Age _______ Date of Birth ___________

School ______________________________

Grade (Current Grade)______________________

____
Player's Position Years of Exp

MORRIS SELECT LACROSSE

Medical Information

Medical Insurance Co.

____

Policy/Group Number

____

Emergency Contact Person

____

Emergency Contact Phone Number

____

I authorize a representative of ***MORRIS SELECT LACROSSE*** to take my child to a physician or hospital. I certify that my son is in good physical condition to participate on the ***MORRIS SELECT LACROSSE*** Team.

A medical clearance form from your family physician or doctor indicating good health and permission to participate is <u>required</u> prior to the first practice.

____
Signature of Parent/Guardian

____
Date

All ***MORRIS SELECT LACROSSE*** players must be members of US Lacrosse

I.D.____________________________________

REGISTRATION FEE

_________ DEPOSIT ENCLOSED

_________ PAYMENT IN FULL ENCLOSED