RIVERA MEMORIAL FOUNDATION, INC.

YOUTH SPORTS APPLICATION

Please print clearly. Parents may only register their own children. Please complete a separate form for each child.

Player's Name: ______________________________ ______________________________
First Last

Address: ______________________________/______________________/______/__________
No. & Street City State Zip

Birth date (MM/DD/YY): _____/_____/_____ Shirt Size:YM Y L YXL AS AM AL AXL

SKILL LEVEL: ☐ **BEGINNER/NOVICE** ☐ **ADVANCED BEGINNER** ☐ **INTERMEDIATE**

Player's Name__________________________ Shirt Size:YM Y L YXL AS AM AL AXL
Player's Name__________________________ Shirt Size:YM Y L YXL AS AM AL AXL

Mother's/Guardian's Name: ______________________________ Phone: ______________________

Father's/Guardian's Name: ______________________________ Phone: ______________________

Contact E-mail Address: (Name) ______________________________

List any medical problem or prohibitions player has: ______________________________

Person to notify in emergency: ______________________ Relation: ____________ Phone: __________

Doctor to notify in emergency: ______________________________ Phone: __________

WAIVER OF LIABILITY & CONSENT FOR MEDICAL TREATMENT

I, the parent/guardian of the registrant, a minor, agree that I and the registrant will abide by the rules and regulations of the Rivera Memorial Foundation, New Opportunities, Inc., City of Waterbury, and all its agents. Recognizing the possibility of physical injury associated with the Program and in consideration for the Rivera Memorial Foundation accepting the registrant for its youth league, I hereby release, discharge and/or otherwise indemnify the Rivera Memorial Foundation, New Opportunities, Inc., City of Waterbury, and all its agents, its agents, sponsors, their employees associated personnel against any claim by or on behalf of the registrant as a result of the registrant's participation in the program. As well, I hereby give 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, limb or well-being of my dependent.

☐ I/We, the parents/guardians of the above named child, do hereby give consent to the Rivera Memorial Foundation to use any photos taken at any event of my child for publicity purposes.

☐ I/We, the parents/guardians of the above named child, have received and read the parent code of conduct and agree to abide by its rules.

Print Name: ______________________ Signature: ______________________ Date: ____/____/_____

Parent/Legal Guardian: ____**Contact information same as above** ___ **Contact information different from above** *(Complete the following)*

Address:

______________________________/______________________/______/__________
No. & Street City State Zip

______________________________/______________________________
Phone No.: Home Cell or Work

FOR RMF, INC. OFFICE USE ONLY

Date: _____/_____/________ Amount Paid $__________ Check #: __________ Receipt #: __________ Staff Initials: _________

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YOUTH SPORTS APPLICATION

RACE:

____ White ____ Black ____ Asian ____ American Indian ____Pacific Islander ____ Other

HISPANIC/LATINO: ___YES ___NO

FAMILY STATUS: Check the line that best describes the adults living in the students home at the present time.

____ Mother & Father ____ Mother only ____ Father only

____ Mother & Stepfather ____ Father & Stepmother ____ Foster Parents

____ Other relatives ____ Other (please specify) ______________________

HOUSEHOLD STATUS: Number of persons living in the student's home at the present time. _________

HOUSEHOLD INCOME: It is important to know about the household income levels of the students using the center.

Does the household receive AFDC / TFA? ____ Yes ____ No

Does the student receive free / reduced price meals at school? ____ Yes ____ No

Please select the appropriate range your household income falls in at the present time:

___ $ 0-$1,000/ month **OR** $0-$12,000/ year ___$1,001- $2,000/month **OR** $12,001-24,00/year

___ $2,001-$3,000/month **OR** $24,001-$36,000/year ___ $3,001-$4,000/ month **OR** $36,001-48,000/year

___ $4,001/ month **OR** $48,001/year ___ OTHER

All information provided is CONFIDENTIAL, and used for grant purposes