



# \_\_\_\_\_

## ***Player Profile and Emergency Information***

Player Name \_\_\_\_\_ Grade Level in Fall 2011 \_\_\_\_\_

Address \_\_\_\_\_ DOB \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Position Played

Requested Jersey #'s:

\_\_\_\_\_

Sweatshirt Size: \_\_\_\_\_ Pant Size: \_\_\_\_\_ Jersey Size: \_\_\_\_\_ Shoe Size: \_\_\_\_\_

Cleat Choice: (Varsity Only) \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_

### Alternate Emergency Contacts

Name: \_\_\_\_\_ Ph #: \_\_\_\_\_

Name: \_\_\_\_\_ Ph #: \_\_\_\_\_

Name: \_\_\_\_\_ Ph #: \_\_\_\_\_

### Medical Insurance Information

Insurance Carrier: \_\_\_\_\_ Subscriber #: \_\_\_\_\_

As the parent or legal guardian of \_\_\_\_\_, I hereby give consent to LB Poly Football Program/ LBUSD to provide all emergency dental and medical care prescribed by a dully licensed physician (MD), Osteopath (DO) or dentist (DDS) to be given under any conditions necessary to preserve life, limb, or well being of my dependent. All Players must have valid medical insurance.

Allergies to Medications: \_\_\_\_\_

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

\_\_\_\_\_  
Date