



# BLACK WIDOWS BASEBALL CLUB, LLC

<b>Players Name:</b>	<b>Birth Date:</b> /     /
<b>Address:</b>	<b>Mother's Name:</b>
<b>City:</b>	<b>Mother's Work#</b>
<b>Zip Code:</b>	<b>Mother's Cell#</b>
<b>Home Phone:</b>	
<b>E-Mail #1:</b>	<b>Father's Name:</b>
<b>E-Mail #2:</b>	<b>Father's Work#</b>
<b>E-Mail #3:</b>	<b>Father's Cell#</b>
<b>Player's email:</b>	<b>Player's Cell#</b>

## PARENTS PERMISSION AND MEDICAL RELEASE

I, \_\_\_\_\_, parent of \_\_\_\_\_, a minor, do hereby give consent for my child to participate in any and all of the activities of the **Black Widows Baseball Club** (hereafter BWBBC) for the duration of my child's association as a team member. I do further release, absolve, indemnify, and hold harmless any and all of the organizers, sponsors, directors, coaches, volunteers, or other persons associated with the BWBBC. In case of injury to my child, I hereby waive any claims against the coaches, organizers, and/or any supervisors appointed by them. I likewise waive, to the extent not covered by liability insurance, any claim against any person given permission to transport my child to and from the activities associated with the team.

I hereby authorize and consent to an x-ray, examination, anesthetic, medical or surgical treatment deemed necessary and rendered under the general supervision of any member of the medical or emergency room staff licensed under the provisions of the Medicine Practice Act and employed by any general hospital holding a current license to operate a hospital from the State of California, Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power to render care in which an aforementioned physician, in the exercise of his/her best judgment, deems advisable. It is also understood that all practical efforts shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above mentioned treatments shall not be withheld in the event that the undersigned cannot be contacted.

It is also understood that any Insurance Coverage carried by BWBBC shall be deemed secondary to the Medical Coverage carried by the undersigned in the event of any injuries sustained while my child is a participant in any BWBBC activities or events during their association with the organization.

\_\_\_\_\_  
**(Signature of Parent or Legal Guardian)**

\_\_\_\_\_  
**(Printed Name Of Parent / Legal Guardian)**

\_\_\_\_\_  
**(Emergency Contact -Other than Parent)**

\_\_\_\_\_  
**(Emergency Contact Phone Number)**

\_\_\_\_\_  
**(Medical Insurance Carrier Name)**

\_\_\_\_\_  
**(Policy/Group Number)**

\_\_\_\_\_  
**(Physicians Name)**

\_\_\_\_\_  
**(Physicians Phone Number)**

**Today's Date:** \_\_\_\_\_