71 Sawyer Avenue, West Babylon, NY 11704

# Summer Registration Form

Year: 2019

Fall Winter
Summer Spring

*Please check off all that are applicable:* ***Note: Program cost and eligibility requirements varies****

- ☐ Street Hockey 7/15-19
- ☐ Street Hockey 7/22-26
- ☐ Lacrosse 7/29-8/2
- ☐ Boys Basketball 7/8-12th
- ☐ Girls Basketball 8/5-9th
- ☐ Boys Basketball 8/12-16
- ☐ Volleyball 8/19-23rd

**Please check our website (wbcyc.org) or call us for program cost and eligibility requirements for each program.**

*Participant Information*: (please print)

Last Name: _____ First name: _____

Address: _____

City/Town: _____ Zip: _____

Email: _____ **Cell Phone**: _____

**Date Of Birth**: _____ **Age:** _____ **Gender:** _____

School: _____ Grade (entering Fall 2017) _____

*Parent/Guardian Information* (Please Print)

Full Name: _____ Cell Phone: _____

Full Name: _____ Cell Phone: _____

Address (If Different from participant): _____

*Emergency Contact:* (please print) – ***(You do not need to complete if registering for Summer Clinics)***

Contact Full Name: _____ Relationship to participant: _____

Home/Cell Phone: _____

I hereby give permission for the above registrant to participate in the WBCYC program selected above. I understand that I am responsible for the care of any equipment used. I will return the equipment promptly when requested to do so by the WBCYC Coach, Counselor or League Official. I fully understand that the registrant will play according to the rules governed by the League or Clinic Officials I give permission for the League to utilize the registrant's team or individual photo for the WBCYC programs, website, promotional literature or press releases in local media.

I hereby certify that participant is in good physical condition to the best of my knowledge. I will not hold the WBCYC liable for any pre-existing conditions. I assume all risks and hazards incidental to such participation including transportation to and from activities. I hereby waive, resolve, absolve, indemnify, and agree to hold harmless the WBCYC, the organizers, sponsors, supervisors, and participants for any claims arising out of an injury to the registrant, except to the extent and in the amount covered by accidental or liability insurance. **Additionally, I am aware that I am responsible to report to the WBCYC Program Director, any injury to registrant related to League play immediately. Failure to report an incident within 24 hours of the incident will result in the claim not being processed.**

**CHIP Parent or Guardian (over 18yrs) – **1.** MUST stay at the WBCYC during the child's class **2.** MUST sign the child in and out of class **3.** MUST have ID. All parents or guardians will wait in the parent room for the duration of class. Excessive absences and aggressive behavior will not be tolerated. A trial period of will determine the eligibility of the participant. NO Siblings are permitted to play during class.*

**Parent Signature** _____

**Official Use Only:** Date Received: _____ Donation: _____ Check Cash

Check#: _____ Receipt #: _____ Waiver _____ Birth Cert attached.: Y N

Form complete: Y N NEED: COE BC PYM Other _____ Initials: _____

A B W H O Group _____ Time _____ Notices _____

WBCYC

Child's Name: _____

## Code of Ethics For Parents

**As a Parent, I am aware of the tremendous influence I have over the emotional and physical well being of my child and I will:**

**NEVER** place the value of winning above the value of instilling sportsmanship and teamwork.

**Encourage** good sportsmanship by demonstrating positive support for all players, coaches, and officials at every game, practice or event.

**Place** the emotional and physical well being of my child ahead of my personal desire to win.

**To** the best of my ability, make sure the playing experience is fun.

**Insist** that my child play in a safe and healthy environment.

**Demand** a sports environment for my child that is free from drugs, tobacco and alcohol.

**Make** sure that my child treats other players, coaches, fans and officials with respect regardless of race, sex, creed or ability.

**Require** my child's coach to uphold the Code of Ethics for Coaches.

**Support** coaches and officials working with my child, in order to encourage a positive and enjoyable experience for all.

**NEVER** interfere with the play of the game. This does not include any injury situation related to my child.

**Remember** that my inappropriate conduct will result in EXPULSION from the play area.

I understand the Code of Ethics for Parents, as set forth by the West Babylon Community Youth Center and by signing this paper, I agree to abide by these codes,.

_____
Print Parent's Name

_____
Parents Signature

71 Sawyer Avenue, West Babylon, NY 11704

Session: AM PM

# SUMMER CLINIC EMERGENCY INFORMATION

*Emergency Contact and/or Child Pick-up* (please print)

****Please list any individual(s) if OTHER than parent or guardian that may be contacted in the event of an emergency or permitted to pick-up child****

Full Name: _____ Home/Cell Phone:_____

Relationship to participant:_____ Circle one: ER Contact PICK-UP ONLY BOTH

Full Name: _____ Home/Cell Phone:_____

Relationship to participant:_____ Circle one: ER Contact PICK-UP ONLY BOTH

Full Name: _____ Home/Cell Phone:_____

Relationship to participant:_____ Circle one: ER Contact PICK-UP ONLY BOTH

Full Name: _____ Home/Cell Phone:_____

Relationship to participant:_____ Circle one: ER Contact PICK-UP ONLY BOTH

Full Name: _____ Home/Cell Phone:_____

Relationship to participant:_____ Circle one: ER Contact PICK-UP ONLY BOTH

*Medical Information (Please print)*

Does the applicant have any food allergies? _____ If so, what type? _____

Is the applicant on a special diet? _____ If so, what type?_____

**PLEASE NOTE: If you have answered "YES" to any of the above questions, please answer the following questions:**

**My child can eat snack provided by WBCYC Yes _____ No _____**

**I WILL provide a suitable snack for my child Yes _____ No _____**

**I understand that NO accommodations will be considered by the WBCYC with regard to food allergies and special diet requirements of my child Yes _____ No _____**

*In Case of Emergency, I hereby authorize any New York State Licensed Medical Professional, or Hospital to perform any treatment necessary to assist my son, daughter, foster child, or ward.*
*(Please print)*

Participant Name: _____

Parent/Guardian's Name:_____

Parent/Guardian's Signature: _____

If you should have any questions, please contact the office at your convenience. Thank you