



BLUE DEVIL REC BASKETBALL



BOYS AND GIRLS, GRADES 3 – 6
SATURDAYS, BEGINNING DECEMBER 10, 2016

WICKLIFFE HIGH SCHOOL GYM

WICKLIFFE RESIDENTS: \$60 / NON-RESIDENTS: \$65

LIMITED TO THE FIRST 80 THAT PAY * VOLUNTEER PARENT ASSISTANT COACHES NEEDED

**Program begins Saturday, December 10. All players are required to attend this workout.
5th & 6th graders report at 9 am at Wickliffe High School gym and 3rd & 4th graders at 10:30 am.
Teams selected after workout. Practice on Wednesday nights will be assigned after workout.**

Photographs are occasionally taken at Recreation Department activities to memorialize past and promote future events. By registering for any Wickliffe Recreation Department program, you grant permission to the City of Wickliffe for the publication of any photos taken during such programs for use in public presentations, advertising, publicity and promotions relating thereto.

CUT AND RETURN BOTTOM SECTION AND FEE TO
WICKLIFFE RECREATION DEPARTMENT, 28730 RIDGE RD, WICKLIFFE 44092,
CHECKS PAYABLE TO: "THE CITY OF WICKLIFFE";
QUESTIONS? - PHONE: 943-7120

**RESIDENT REGISTRATION STARTS OCT. 17, MON.-FRI., 8AM - 4PM.
NON RESIDENT REGISTRATION STARTS NOV. 1.**

BLUE DEVIL BASKETBALL REGISTRATION FORM (PLEASE PRINT)

PLAYER'S NAME _____ BIRTH DATE _____ AGE _____ MALE / FEMALE

ADDRESS _____ CITY _____ ZIP _____

PHONE # _____ OR _____

E-MAIL ADDRESS _____ SCHOOL _____ GRADE _____

SHIRT SIZE (CIRCLE ONE): YOUTH-MED (10-12) YOUTH-LG (14-16) ADULT- SM ADUL T- MED ADUL- LG ADULT- XL

LIST ANY CRITICAL MEDICAL INFORMATION CONCERNING THIS CHILD (ALLERGIES, ASTHMA, HEART CONDITION, OTHER):

(CIRCLE ONE) **IDO / I DO NOT** give my consent for emergency medical treatment for my child in the event reasonable attempts to contact me or my spouse have been unsuccessful. The authorization for medical treatment does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity of such surgery are obtained prior to the performance of such surgery. If you choose to not grant consent for medical treatment, program authorities will take no action.

CHILD'S PHYSICIAN _____ PHONE# _____

CHILD'S DENTIST _____ PHONE# _____

IF INTERESTED IN BEING A VOLUNTEER PARENT ASSISTANT COACH, PLEASE FILL OUT THIS SECTION
To better protect our children, the City of Wickliffe's Law Department and our risk management consultants have authorized the initiation of a basic background check for our coaches.
Ohio's "Return to Play" training required.
NAME _____ PHONE # _____

In case of loss or injury while participating in Wickliffe Recreation Department Programs, I, the parent/guardian, release from liability The City of Wickliffe, Wickliffe City Schools and any and all personnel and/or volunteers associated with this recreation program.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

OFFICE USE ONLY

FEE \$ _____ CASH CHECK# _____ RECEIVED BY _____ DATE _____