

PARENT / GUARDIAN INFORMATION

Father/Guardian Last Name: _____ First Name: _____

Address: _____
 (OR SAME) STREET CITY STATE ZIP CODE

Home Phone: (____) _____ Work Phone: (____) _____ Cell: (____) _____
 (OR SAME)

Email Address: _____

Mother/Guardian Last Name: _____ First Name: _____

Address: _____
 (OR SAME) STREET CITY STATE ZIP CODE

Home Phone: (____) _____ Work Phone: (____) _____ Cell: (____) _____
 (OR SAME)

Email Address: _____

PWYB/S is a volunteer organization. Our continued success relies on member support and participation. Please enter name(s) in your area of interest (At least 2 volunteer hours per family is appreciated).

TEAM LEVEL VOLUNTEER				ORGANIZATION-LEVEL VOLUNTEER	
Note your volunteer name under the corresponding player				Please note your volunteer name	
Player	#1	#2	#3	Concessions: _____	Fund Raising: _____
Head Coach	_____	_____	_____	Uniforms: _____	Equipment: _____
Assistant Coach	_____	_____	_____	Field Maint.: _____	Pictures: _____
Team Coordinator	_____	_____	_____	Tournament Support: _____	

SAVE THE DATE: SKILLS ASSESSMENT DAY WILL BE MARCH 31ST FROM 8:00 TO NOON. ALL PLAYERS FOR THE MINOR AND MAJOR DIVISIONS IN THE BASEBALL LEAGUE AND THE MAJOR DIVISION OF THE SOFTBALL LEAGUE ARE STRONGLY ENCOURAGED TO PARTICIPATE

REMEMBER TO REGISTER EARLY – UNIFORM ORDER DEPENDS UPON REGISTERING BY MARCH 24th

PARENTAL REQUEST: PLEASE LIST BELOW THE FAMILY MEMBERS THAT YOU WANT TO PLAY ON THE SAME TEAM. PWYB/S will only guarantee siblings on the same team, if in the same league. **You may request to play with friends or other relatives in Tee-Ball ONLY.**

NAME	GRADE	NAME	GRADE	NAME	GRADE
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EMERGENCY INFORMATION:

Emergency Contact other than Parent / Guardian: _____ Phone #: (____) _____

Doctor's Name _____ Phone #: (____) _____

Medical information (if any) coaches should be aware of (allergies, etc.) _____

I certify that the above information is true and correct. Port Washington Youth Baseball/Softball and the City of Port Washington are to be held free and harmless from any liability that may arise while my child(ren) or dependent(s) is/are participating in any league activity. My consent is hereby given for emergency medical care prescribed by a duly licensed Doctor of Medicine or Dentistry. This care may be given under whatever conditions are necessary to preserve life, limb, or the well-being of my child(ren).

Signature of Parent or Guardian: _____ **Date:** _____

"The opinions expressed (information provided) are NOT sponsored or endorsed by the Port Washington-Saukville School District or its personnel."