

CVHAA
PATRIOTS BASEBALL

Player Information Form 2025-26

Player's Full Name: _____

DOB (mm/dd/yyyy): ____/____/____ Grade: ____ Grad Year: ____ Ht/Wt: ____/____

Parent Name(s): _____

Parent Cell/Text Number(s): _____

Parent Email(s): _____

Full Address: _____

Medical Release

In the event of any injury or emergency, if I or my emergency contact cannot be notified, I authorize the Individual(s) in charge to obtain medical treatment for my child as deemed necessary by competent medical personnel. Additionally, I understand that I am fully responsible for any and all charges incurred due to such treatment.

Medications taken: _____

Known allergies: _____

Any other pertinent medical history: _____

Doctor's Name: _____ Doctor's Phone: _____

Doctor's Address: _____

Insurance Provider: _____ Policy #: _____

Emergency contact (other than parent): Name _____

Relationship to Player: _____ Phone: _____

PARENT'S SIGNATURE: _____ **DATE:** _____