Cuyahoga Falls Amateur Baseball Association Registration Form

City of Cuyahoga Falls Parks and Recreation Department
2310 Second Street Cuyahoga Falls, OH 44221
www.cityofcf.com/cfaba

Fee Owed	Paid Check	Paid Check	Paid Credit
$			

(Staff use only): REQUEST BACK IN THE DRAFT

Player First Name	PLACED IN LEAGUE	TB	CP	H	G	F	E
		Years of Experience per League					

Player Last Name	Street Address	Apt
Date of Birth / / Age at start of season (5/1)	City	Zip

Home Phone ( ) -	Mom's Cell Phone ( ) -	Dad's Cell Phone ( ) -
Emergency Contact ( ) -	Mom's Name	Dad's Name

Mom's Email Address	Dad's Email Address

School Attending

Vacation/Conflicts

SHIRTS		PANTS	
Youth X Small		Youth X Small	
Youth Small		Youth Small	
Youth Medium		Youth Medium	
Youth Large		Youth Large	
Adult Small		Adult Small	
Adult Medium		Adult Medium	
Adult Large		Adult Large	
Adult X Large		Adult X Large	
Adult XX Large		Adult XX Large	

Are you able to volunteer?

- Team Manager
- Assistant or Base Coach
- Team Parent
- Help with Fundraisers
- Concessions at Play Day

Cuyahoga Falls Amateur Baseball Association PERMISSION FORM

I agree to play baseball in the league listed above in the C.F.A.B.A. for the current season and to abide by the rules and regulations of the Association.

Signature of the player _____ Date _____ League _____

I, the undersigned, grant permission to my child to participate in the C.F.A.B.A Baseball Program sponsored by the Cuyahoga Falls Parks and Recreation Department For consideration received of the City of Cuyahoga Falls, I agree to release and hold harmless the City of Cuyahoga Falls, C.F.A.B.A, its agents, employees and representatives, from any liability for any injuries sustained by the above named child. In the event reasonable attempts to contact me or the above named person(s) have failed, I hereby consent to (1) any treatment deemed necessary for my child by _____ (Doctor's Name) AT ( ) - (Doctor's Phone number), or if he/she is unavailable, by another licensed physician, and (2) the transfer of my child to _____ (Hospital Name) Hospital or any hospital reasonably necessary. Facts concerning my child's medical history, including allergies, medications being taken, and any other physical impairments are as follows:

Medications / Allergies / Limitations / Etc.

Signed: _____ Date: _____

Signature of Parent or Guardian

Make Checks payable to C.F.A.B.A. Your check is your receipt.

Return this registration by March 1st to:

Cuyahoga Falls Parks and Recreation Department
Attn: CFABA
2310 Second Street
Cuyahoga Falls, Ohio 44221

NOW ACCEPTING CREDIT CARDS

(Circle one)

Visa

Mastercard

Discover

Am. Ex.

/

Expiration Date

CVC Code (Number on back)

Zip Code