



EASTVIEW LITTLE LEAGUE

PO.Box 6401
 Rancho Palos Verdes, Ca. 90734
 (310) 831-1922
agent@eastviewll.com

2010 Fall Ball Application
AGES 6-14
Registration Fee is \$75

For financial assistance please check here:

POSSIBLE TRAVEL TO OTHER LEAGUES WITHIN THE DISTRICT 27
ALL GAMES ARE PLAYED ON SUNDAYS-PRACTICE TIMES ARE UP TO THE COACH

Player's Last Name	First Name	M.I.	M/F M F	Birth Date	2010 Player Age
Played Last Season? Y N		2011 Division: T-Ball Rookie AA AAA Major	Last Season's Team		
Team/Coach/Friend Request					

PARENT/GUARDIAN INFORMATION

Father's Name			Mother's Name		
Street Address			Street Address		
City, State, Zip			City, State, Zip		
Home Phone:	Work:	Cell:	Home Phone	Work	Cell
Email:			Email:		

Parent participation in the League is vital and expected-Please indicate choices:

Dad	Mom	Manager	Dad	Mom	Score	Dad	Mom	Team Parent
_____	_____	_____	_____	_____	_____	_____	_____	_____
		Coach			Grounds			Auxiliary
		A. Coach			Sponsor			Snack Bar

PARENT'S PERMISSION AND MEDICAL INFORMATION

I/We the parent(s) or guardian of the above-named child, hereby give my/our approval to this participation and all of the activities of Eastview Little League during the current season. I/We assume all risks and hazards incidental to the conduct of the activities and transportation to and from the activities. I/We do further release, absolve, indemnify and hold harmless Eastview Little League inc.; the organizers, sponsors, directors and the supervisors, and or all of them. In case of injury to my/our child, I/We hereby waive all claims against the organizers, sponsors, directors or any of the supervisors appointed by them. I/We likewise wave, to the extent not covered by liability insurance, any claim against any person transporting my/our child to or from the activities. I/We will furnish certified birth certificates of the above-named registrant upon the request of Little League officials.

I/We the undersigned parent(s) or legal guardian of _____, a minor, do hereby authorize and consent to an X-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any general hospital holding a current license to operate a hospital from the State of California, Department of Public Health.

It is understood that this authorization is given in advance of any specific diagnosis, treatment of hospital care being required, but is given to provide authority and power to render care which the aforementioned physician, in the exercise of his better judgement, may deem advisable. It is understood that efforts shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above mentioned treatments will not be withheld if the undersigned cannot be reached.

Parent(s) or Legal Guardian(s) Signature _____

Allergies or information relating to the minors health					
Emergency contact Name		Phone		Physician's Name	
Father's Health Insurance Carrier		Member Number		Authorization Phone Number	
Mother's Health Insurance Carrier		Member Number		Authorization Phone Number	

All applications may be mailed to the above address.

All Executive Board and Coaching Positions are held by League Volunteers donating their time for the Kids of Eastview.
 We ask that all parents and spectators show respect at all times to make this a positive experience for all.