MUSKOGEE YOUTH BASEBALL ASSOCIATION

P.O. Box 1842 • Muskogee, OK 74402 • www.muskogeeyouthbaseball.com

Muskogee Youth Baseball Association (hereinafter MYBA) and ____________________, (hereafter
Parents Name

Parent(s)) the Parent (s) Legal Guardian of ______________________________(hereafter Child) do
Child's Name

On this date ______________, mutually promise, covenant and agree as follows:

1. Consideration

1.1. In consideration for the fee paid under paragraph 1.2, MYBA agrees to allow Child to participate in sporting activities sponsored or run by MYBA subject, however to the adherence to the rules and regulations of Muskogee Youth Baseball Program.

1.2. (a) In consideration of the promise in paragraph 1.1, Parent (s) agree to pay the registration fee of $ ________ .

(b) In lieu of the payment in 1.2 (a), payment may be made by the Child's team.

(c) In lieu of the payment in 1.2 (a) or (b), scholarships may be awarded as deemed necessary in the case of hardship with Board of Directors approval.

AUTHORIZATION FOR EMERGENCY CARE TO MINOR (S)

I/We the undersigned, parent(s) or legal guardian(s) of ________________________ born:________
Child's name Birthday

do hereby authorize any X-ray examination, anesthetic, dental, medical, or surgical diagnosis or treatment by any physician or dentist licensed by the State and hospital service that may be rendered to Child under the general, specific or special consent of:

____
Team Name

____
(Name of adult coach who is temporary custodian of minor)

____
(Name of adult coach who is temporary custodian of minor)

the temporary custodian of Child; whether such diagnosis or treatment is rendered at the office of the physician or dentist, or at a hospital licensed by the State. I/We further authorize the physician or dentist to call in any necessary consultants, in their discretion. I/We further authorize said physician or dentist to exercise their discretion in authorizing the disposal of any severed tissues or member.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage that person who has temporary custody of Child, and said physician or dentist to exercise their best judgement as to the requirements of such medical, surgical or dental diagnosis or treatment. This consent shall remain effective until _________ am, on the _____day of ________, 20__, unless sooner revoked in writing, delivered to said physician or dentist, or said person entrusted with the custody, care, and control of said minor child or children.

______________________________ __________ ______________________
Parent or Legal Guardian (Print) Date Witness signature

____, ____________,___, __________
Street address Mailing address City St Zip

__________ __________ ______________________________
Home Phone Emergency Phone Parent or Legal Guardian (signature)