



MANKATO AREA YOUTH BASEBALL ASSOCIATION
1925 HAUGHTON AVENUE
NORTH MANKATO, MN 56003
PHONE: (507) 625-3802; FAX: (507) 625-3854
WEB SITE: www.mayba.com or travel_manager@mayba.com

Greater Mankato Area
 United Way



Minnesota Charitable Gaming License #31040

CONSENT TO TREAT

This is to certify that on this date, I _____ as parent(s) or guardian of _____, give my consent to a representative of the Mankato Area Youth Baseball Association (MAYBA), namely a coach, to obtain medical care from any licensed physician, hospital or clinic for the above mentioned athlete, for any injury that could arise from participation in MAYBA sanctioned events.

If said athlete is covered by any insurance policy, please complete the following:

Name of Insurance Company _____

Address _____

Policy Number _____ Group Number (if applicable) _____

Signature _____
 (Parent/Guardian)

Relation to athlete _____ Date _____

Home Address _____

Home Phone: _____ Cell Phone: _____

Health Information—Hold Harmless Agreement

We the parents or guardians, certify that we have read this registration form thoroughly and completely and information included on both pages of this form is true, accurate and complete. As parents/guardians, we understand that this program is a youth baseball program and as such involves certain risks of injury to the participants. Having in mind the risk of injury, we as parents/guardians do hereby agree to assume responsibility for the illness injury or injuries sustained by _____ (**player's name**) while practicing, playing, being transported or involved in any activities under the jurisdiction of the Mankato Area Youth Baseball Association (MAYBA). We also agree to INDEMNIFY AND HOLD HARMLESS the Community Services Recreation Department, the Mankato Public and Parochial School Systems, the Mankato Area Youth Baseball Association (MAYBA) and the cities of Mankato and North Mankato from any and all damages while participating in youth baseball.

_____ Parent/Guardian Signature

Medical History Form

Name _____ Date _____

Address _____ Date of Birth _____

Daytime Phone _____ Evening Phone _____

In case of emergency, contact: Name _____ Relationship _____

Daytime Phone: _____ Evening Phone: _____ Cell Phone: _____

Physiciain's Name _____ Daytime Phone: _____ Hospital _____

PLEASE COMPLETE THE FOLLOWING:

If the answer to any of the following questions is or was yes, please describe the problem and it's implications for proper first aid treatment on a separate piece of paper:

Have you had (or do you presently have) any of the following?

Head Injury (concussion, skull fracture)	Yes	No
Fainting spells	Yes	No
Neck or back injury	Yes	No
Asthma	Yes	No
High blood pressure	Yes	No
Kidney problems	Yes	No
Hernia	Yes	No
Diabetes	Yes	No
Heart murmur	Yes	No
Allergies: Specify _____	Yes	No
Injuries to:		
Shoulder	Yes	No
Knee	Yes	No
Ankle	Yes	No
Fingers	Yes	No
Arm	Yes	No
Other _____		

Impaired vision Yes No

Impaired hearing Yes No

Have you had a recent tetnus booster? _____ If so, when? _____

Are you currently taking any medications _____ What? Why? _____

Has the doctor placed any restrictions on your activity? Yes No. Explain _____

Signed _____ Date _____
(Athlete)

Signed _____ Date _____
(Parent)