

# TRI-STATE ATHLETIC CLUB MEMBERSHIP FORM

YOUR TSAC MEMBERSHIP IS VALID FOR ONE YEAR FROM INITIAL SEASON OF COMPETITION. RETURN THIS SHEET, ONE SHEET PER CHILD, WITH A CHECK OR MONEY ORDER FOR **\$100.00 THE FIRST FAMILY MEMBER + \$50 FOR EACH ADDITIONAL CHILD** PAYABLE TO: TRI-STATE ATHLETIC CLUB. MAIL THE FORM AND CHECK TO:

JASON LEA  
TRI-STATE ATHLETIC CLUB  
340 6<sup>th</sup> Ave. Apt. 8  
HTUNTINGTON, WV 25701

**PLEASE RETURN A COPY OF PROOF OF BIRTH AND A SMALL PICTURE OF THE ATHLETE(S) WITH YOUR REGISTRATION.**

PLEASE PRINT NEATLY!!!!!!!!!!!!!!

ATHLETE NAME \_\_\_\_\_ AGE \_\_\_\_\_ MALE / FEMALE  
MAILING ADDRESS \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ SCHOOL \_\_\_\_\_ GRADUATION YEAR \_\_\_\_\_  
E-MAIL ADDRESS \_\_\_\_\_

## EMERGENCY INFORMATION

LIST MEDICAL CONDITIONS/ALLERGIES \_\_\_\_\_  
PRIMARY PHYSICIAN NAME \_\_\_\_\_ PHONE# \_\_\_\_\_  
MEDICAL INSURANCE PROVIDER \_\_\_\_\_ POLICY# \_\_\_\_\_  
MOTHER/GUARDIAN NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ PAGER \_\_\_\_\_  
FATHER/GUARDIAN NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ PAGER \_\_\_\_\_

## UNIFORM INFORMATION

SINGLET (PLEASE CIRCLE) YOUTH / ADULT S M L XL XXL

SHORTS (PLEASE CIRCLE) YOUTH / ADULT SHORTS / BRIEFS (HS GIRLS ONLY) S M L XL XXL

IN CONSIDERATION OF THE PERMISSION GRANTED TO THE BELOW NAMED ATHLETE BY TRI-STATE ATHLETIC CLUB (TSAC) TO PARTICIPATE IN ANY OF IT'S PROGRAMS, I RELEASE TSAC AND IT'S AGENTS FROM ALL ACTIONS, DAMAGES, CLAIMS OR DEMANDS WHICH I, MY HEIRS, EXECUTORS, ADMINISTRATORS OR ASSIGNS MAY HAVE AGAINST TSAC FOR ALL INJURIES KNOWN OR UNKNOWN WHICH THE BELOW NAMED ATHLETE MAY INCUR BY PARTICIPATING IN TSAC PROGRAMS. I ALSO AGREE TO RELEASE AND HOLD HARMLESS TSAC FOR ANY SUSTAINED DAMAGES. I ALSO STATE THAT THE BELOW NAMED ATHLETE HAS BEEN APPROVED BY A LICENSED MEDICAL PHYSICIAN TO PARTICIPATE IN ANY OF TSAC'S PROGRAMS.

I AUTHORIZE ANY MEDICAL EXAM, IMAGING, ANESTHETIC, MEDICAL OR SURGICAL TREATMENT, HOSPITAL CARE OR EMERGENCY PROCEDURES, INCLUDING LIFE SAVING MEASURES, TO BE RENDERED TO THE BELOW NAMED ATHLETE WHEN NECESSARY.

ATHLETE NAME \_\_\_\_\_ ATHLETE SIGNATURE \_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_