2017 – 2018 Overtime League
OUTSIDE TEAM PLAYER Registration Form
Grades 3 thru 9
Deadline: Weds, November 22, 2017

League begins Saturday, December 16th, 2017

Full team payment of $470 to be sent or paid online by coach or team parent (each team also pays one $30 referee fee at each game – this fee can also be paid in advance by team for 10 regular season games @ $330 per team).

Coach to send this form for each player (signed by parent) along with team roster form and payment to:
Renegades, 858 Street Road, Southampton, PA 18966 OR
Send by fax (215) 364-3629 OR EMAIL to parenegades@comcast.net

- **Games will be played at Kelly Bolish Gym, 2950 Turnpike Drive, Hatboro, PA 19040**
- **Weekly Schedule will be posted to our website: www.renegadesbasketball.com**
- **Questions regarding the league can be sent to (preferred) parenegades@comcast.net**
- **Club Phone: (215) 919-0019**

NOTE: IF THERE ARE ANY WEATHER RELATED COMMUNICATIONS/CANCELLATIONS, CLICK ON THE SPINNING BASKETBALL IN THE UPPER RIGHT HAND CORNER OF OUR WEBSITE FOR GYM CLOSURE INFO.

NAME _____ AGE_____ BIRTHDATE _____ GRADE _____HT_____

ADDRESS_____ CITY _____ ZIP_____

BOY or GIRL (CIRCLE)

HOME PHONE # _____ DAD'SNAME_____MOM'SNAME_____

DAD'S WORK # _____ DAD'S CELL # _____MOM'S WORK#_____

MOM'S CELL #_____ E-MAIL ADDRESS _____

Team Name _____Coach's Name _____

YOUR CHILD'S NAME:_____ has my permission to participate in the 2017-2018 Winter Program. I hereby assume all risks associated with the participation of my child in the Renegades Overtime or other league, and agree to hold harmless the Renegades AAU organization, their officers, coaches, and participants for any and all claims for injuries arising out of the participation in this program. I understand the details of this form and attest to its accuracy. All persons are required to be covered by a personal or family medical plan including hospitalization before they can participate in the program; I certify that the person named above is covered by such a plan. I the undersigned parent (legal guardian), do hereby grant permission to any licensed physician to perform or provide necessary medical care or aid to my child or ward who was injured in connection to the playing of basketball.

Date _____ Signature _____

9/5/17 revised