www.stevescafabaseball.com
516-375-4155

REGISTRATION FORM
STEVE SCAFA BASEBALL CAMP

(Last Name) ____________________________(First Name)______________________________

School: ____Home phone: _____________

Home Address: ____

Grade: September 2012 ______ Age: September 2012 _______ Preferred Email _______________

PARENT NAME(S):

Mother: _______________________Home phone: ___________Cell phone: _________

Employer: _____________________ Work phone: ___________

Father: ________________________Home phone: __________ Cell phone: _____________

Employer: ____ Work phone: _______________

INSURANCE INFORMATION:

Primary Health Insurance: ____

Name of Subscriber: ____ I.D.#:_________________

Medical Conditions (allergies, diabetes, etc.)____

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If a family member cannot be contacted, I hereby give permission for Steve Scafa Baseball Camp to arrange for physicians and/or hospitals to proceed with emergency medical treatment for my child, (name)_________________________________, in the event of accidental injury while participating in Steve Scafa Baseball Camps.

Signature: _________________________________ Emergency Contact No.:______________

Alternate contact person: _______________________Relationship:______________________

Alternate Contact Person Emergency Phone No.: ___________________________________

Program offerings are subject to minimum enrollments and fees will be refunded in the event of course cancellation. Checks should be made out to Steve Scafa Baseball Camps. Thank You!