



# MEMBER REGISTRATION FORM

Email completed form to: craigieburnsoftball@gmail.com  
Deposit Registration Fees into the following Bank Account:-  
BSB: 633000 Acc: 149971830 Acc Name: Craigieburn Softball Club Inc.  
Note: Please include your surname in the transaction description.

Season	Deposit Rec #
2017/2018	

## Personal Details

Player Name:	Date of Birth: / /
Parent/Guardian Name (Junior Players):	
Address:	Postcode:
Contact Numbers: Home:	Mobile:
Email:	

## Medical & Emergency Contact Information (☒ Applicable ☒ Not Applicable)

Name of the person to be contacted in case of injury:		
Relationship to Player:		
Contact Numbers: Home:	Business:	Mobile:
The disclosure of the following information is completely voluntary and if provided will be divulged only to the Craigieburn Softball Club Committee, Team Coach and Team Manager for assistance with any medical emergency occurring during the season including training, warm up or playing softball on scheduled game days. I give permission to call an ambulance in an emergency: <input type="checkbox"/> YES <input type="checkbox"/> NO Medicare No.: ..... Doctor Name: ..... Doctor Phone: ..... <i>Please complete the Medical Information details on page 2.</i>		

COMPLETION OF MEDICAL INFORMATION IS  
REQUIRED FOR MEMBERSHIP APPROVAL.

## Additional Information: (☒ Applicable ☒ Not Applicable)

What are your preferred positions (if any): 1. 2. 3.		
Have you or your child played before for any other club? <input type="checkbox"/> YES <input type="checkbox"/> NO		
If YES then please complete the following:- Year last played:		
Name of the Club:	Name of the Association (if known):	
Uniform Sizes: Top:	Pants:	Socks:
I authorise Craigieburn Softball Club to use of my/my child's/ward's image/photo for the sole purpose of promoting the game of Softball and the Craigieburn Softball Club: <input type="checkbox"/> YES <input type="checkbox"/> NO		

I (name/parent/guardian name) ....., by signing this form confirm that all details are correct and agree to be bound by the Constitution, By-Laws and Policies of the Craigieburn Softball Club Inc. I agree to indemnify Craigieburn Softball Club and it's appointed representatives from any claims arising out of personal accident or property damage however caused while I am a member of the club. I understand that the Club is subject to the Privacy Act 1988. The primary reason for the collection of this information is so that the Club can from time to time communicate with me, using information supplied on this application form. I understand that I can access information relating to my membership or opt out of communication at any time by contacting the Club. A \$20 deposit is required on registration. The deposit will be deducted from your season fees.

Signature ..... Date .....

☐ T-Ball (4-8yrs) ☐ U12 (8-12yrs) ☐ U16 (12-16yrs) ☐ U19 (16-19yrs) ☐ Open (18+yrs) ☐ Master (35+yrs) ☐ Official

---

## Medical Information:

Is there a medical condition you or your child suffers, including allergies, the Club should be aware of? ☐ YES ☐ NO

The following information is required by Craigieburn Softball Club for use in the event of a medical emergency during softball competitions in which the club participates. The details provided will be divulged on a need to know basis and in accordance with the Privacy Act 1988. Dissemination of this information will be limited to the Craigieburn Softball Club Committee, Team Coach and Team Manager. You can access your personal information through the Craigieburn Softball Club upon request.

By signing the Medical Information form, I consent to the provision of the medical information detailed below by the Craigieburn Softball Club for use in the event of injury, illness or emergency, if required.

I understand that it is my responsibility to notify the club of any changes to the medical information detailed on this form.

Signature ..... Date .....

Private Health Insurance (if applicable) \_\_\_\_\_ No: \_\_\_\_\_

Ambulance Member No: \_\_\_\_\_

Existing medical conditions/injuries/allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Regular medication: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Action Plan for medical conditions/injuries/allergies:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_