

H-TOWN HURRICANES 2022 REGISTRATION FORM

ATHLETE INFORMATION:

Last Name _____

First Name _____

Grade ____ Age ____ Birth date _____ Circle Gender: M or F

School _____

Please provide a copy of your child's birth certificate with completed application.

\$250.00-FEB. 11-28, 2022-EARLY BIRD RATE

\$275 STARTING MARCH 1, 2022

*(Includes: AAU Registration Card- Uniform- T Shirt- Facility Fees) **Track meet entry fees will be billed separately***

\$25 sibling discount up to 2- NO REFUNDS

PARENT OR GUARDIAN INFORMATION:

Last Name _____

First Name _____

Relationship _____ Home Phone _____

Address _____ City _____ Zip _____

Email _____

Last Name _____

First Name _____

Relationship _____ Home Phone _____

Address _____ City _____ Zip _____

Email _____

** There is a \$35.00 assessment fee for all returned checks*

Please Print

I, _____, hereby give permission for my child,

_____,

to participate in the H-Town Hurricanes Youth Track Club Program. I further release the coaching staff and the H-Town Hurricanes Youth Track Club from any responsibility for bodily injury that my child may receive while participating in the program. I understand that I am responsible for any medical fees accrued by my child as a result of medical attention. I give H-Town Hurricanes permission to publish my child's name, photo and participating events on all online platforms including the H-Town Website. I also grant permission to the H-TOWN Hurricanes Youth Track Club to complete all membership forms and registration materials required by the United States Track and Field Association and the Amateur Athletic Union for participation in local and national meets.

Parent/Guardian Signature:

Date:

H- TOWN HURRICANES YOUTH TRACK CLUB

Medical History

Please Print

Applicant's Name: _____
(Last) (First) (MI)

Date of Birth: _____

Has the applicant ever been hospitalized? ____ Yes ____ No

If Yes, Why? _____

Is the applicant Allergic to any Medications? ____ Yes ____ No

If Yes, What? _____

Is the applicant currently using any Medications? ____ Yes ____ No

If Yes, What? _____

Date of last Tetanus Shot: _____

Has the applicant suffered or is presently suffering from any of the following (CIRCLE ALL THAT APPLY)?

Diabetes	Mental Health	Asthma	Excessive Bleeding
Chronic Headaches	Hypertension	Concussions	HIV
Heat Stroke	Herpes	Fainting Spells	Hepatitis/Liver Disease
Heart Disease	Sickle Cell Disease	Heart Murmurs	Hemophilia Stroke
Cystic Fibrosis	Kidney Disease/UTI	Muscular Dystrophy	Skin Problems
Down Syndrome	Neuralgic/Epilepsy	Varicosity/Phlebitis	Autoimmune Disorder
Neural Tube Defect (Spina Bifida)			

Others: _____

Emergency Contact:

Name

Relationship

Phone Number