

Dr. Roy Wilson Learning Centre Baseball Institute Application



The objective of the Dr. Roy Wilson Baseball Institute is to engage students in education through the use of sport and exercise science. Students will have the opportunity to develop athletes through on field activities, physical training, mental training and exercise science as key components.

STUDENT INFORMATION

Student Name:

Last School attended:

Grade:

Date of birth:

Gender:

Phone:

Current address:

City:

Province:

Postal Code:

PARENT INFORMATION

Parent/Guardian Name:

Cell:

Parent/Guardian Name:

Cell:

By signing this Registration I agree to:

1. Adhere to the rules and expectations of the Medicine Hat Public School Division and the Dr. Roy Wilson Learning Centre.
 2. Transportation – travel with the WLC Baseball Institute, under the supervision of the designated teacher/supervisor for each of the trips as schedule for the Baseball Institute;
 3. Facilities – MHHS, WLC, YMCA (Southridge), Temple Fitness, Underground Fitness
 4. Fee \$600 (approx. breakdown) – apparel (\$150), travel (\$250), facilities (\$100), equipment upkeep (\$100)
 5. Options – those enrolled in the Baseball Institute will have **only this option** – 4 days per week from 1:50-3:00 pm)
 6. Complete the District Health Certification an Waiver form
- Any student that suffers financial hardship will be encouraged to contact Medicine Hat Jumpstart and KidSport Programs. Any costs left unpaid at that time will be covered by the Dr. Roy Wilson Baseball Institute.

Signature of Student:

Date

Signature of Parent/Guardian

Date



**HEALTH CERTIFICATION AND PARENT WAIVER FORM
(EXTRA-CURRICULAR ACTIVITIES)**

Student Name: _____ **Date:** _____

HEALTH CERTIFICATION

I am satisfied that my son/daughter _____ is in good health to take part in strenuous activities. He/she has my permission to participate in the extra- curricular activities indicated below and conducted by _____ School.

It is with my knowledge that my son/daughter has been examined by a medical doctor within the last 12 months and has been declared that he/she is physically fit to compete in the following extra-curricular activities indicated below and conducted by _____ School.

I also agree with the need to have my son/daughter examined by a physician following an illness or injury to re-establish the bill of good health and understand that this, or any other medical examination, is my sole responsibility.

Please check each of the sports/clubs below he/she is permitted to try out for and/or take part in:

- | | | | |
|------------------------------------|----------------------------------------------|-------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Badminton | <input checked="" type="checkbox"/> Baseball | <input type="checkbox"/> Basketball | <input type="checkbox"/> Cross Country |
| <input type="checkbox"/> Curling | <input type="checkbox"/> Football | <input type="checkbox"/> Golf | <input type="checkbox"/> Rugby |
| <input type="checkbox"/> Soccer | <input type="checkbox"/> Track & Field | <input type="checkbox"/> Volleyball | |
| <input type="checkbox"/> Band | <input type="checkbox"/> Choir | <input type="checkbox"/> Drama | <input type="checkbox"/> Other: _____
<small>(please specify)</small> |

PERSONAL INFORMATION:

Gender: Male Female

Student's Birthdate: Day: _____ Month: _____ Year: _____ Age as of Sept 1st: _____

Student's Alberta Health Care Number: _____

Additional Health Care Coverage: _____

Name of Physician: _____

Address of Parent/Guardian: _____

Home Telephone Number: _____

Cell or Business Telephone Number of Parent(s): _____

Alternate Contact Person(s): _____

Address of Alternate Person(s): _____

Home Telephone Number of Alternate Contact: _____

Cell or Business Telephone Number of Alternate: _____