

PLEASE RETURN THIS FORM WITH PARTICIPATION FEE OF \$75

Cut along dotted line and return this portion with fee.
To: BYAA, P.O. Box 432, Brainerd, MN. 56401 Questions?
Please call or text Tim Hill @ 218-251-8287

PLEASE PRINT CLEARLY

Players Name: _____ Weight _____
required

Parent/s Name: _____

Parent Email Address: _____

Mailing Address: _____

City: _____ Zip: _____

Parent Phone: (_____) _____ - _____ Text: Yes / No

2020 School: _____ Grade 2020-21: _____

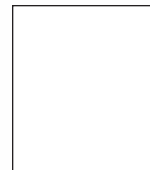
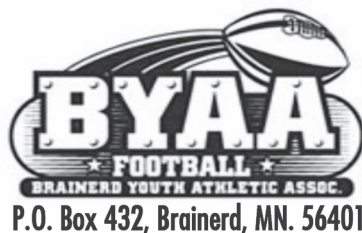
What elementary school did you attend last year (2019-20)?

Did you play football last season? Yes / No

What team? _____ Coaches Name: _____

Yes, I am interesting in helping coach: Lead Assistant

PLEASE COMPLETE FRONT AND BACK





2020 FOOTBALL LEAGUE 4TH & 5TH GRADE TACKLE FOOTBALL

Registration - 1 Night ONLY

When: Monday, August 17

Where: Forestview Football Field #4

Time: 5:30pm to 6:00pm Registration

2 Night Skills Clinic • Sign up with C.E.

When: Monday, August 17 & Tuesday, August 18

Where: Forestview Football Field #4

Time: 6:00pm to 7:00pm

Instructors:

Warrior Varsity, Coaching Staff & Players

Wear shorts, t-shirts, spikes, etc. Free T-shirt included.

Equipment Handed Out: Forestview Equipment Building
(Located behind tennis courts)

Saturday, August 22 from 8:00 am– 9:30 am

PLAYERS FIRST PRACTICE

Monday, August 24th

Forestview Middle School

Players 1st practice 5:30 to 7:00 (FV Fields)

***At Registration, Clinic, and Equipment Handout, please respect social distancing. One parent and student only.**

This form MUST be completed by parent before playing in the BYAA League.

Does this child have a past history of:

- | | | |
|--------------------------------|-----------|----------|
| 1. Heart Disease | Yes _____ | No _____ |
| 2. Epilepsy or fainting spells | Yes _____ | No _____ |
| 3. Diabetes | Yes _____ | No _____ |
| 4. Asthma– Wheezing | | |
| shortness of breath | Yes _____ | No _____ |
| 5. Bruising of bleeding easily | | |
| or blood disease | Yes _____ | No _____ |

PRINT ALL INFORMATION CLEARLY

If yes to any of the above, a physician written approval will be required to participate. Falsification of information will result in ineligibility of the player. We as parents or guardians, do hereby agree to all responsibility for any illness, or injuries sustained by: Print Clearly!

Players Full Name

____/____/____

Players Date of Birth

While practicing, playing, be transported, or involved in activities under the jurisdiction of the Brainerd Youth Athletic Association. We also agree to identify and hold the Brainerd Park and recreation Department, ISD 181, and the Brainerd Youth Athletic Association and its representatives and the City of Brainerd from any and all damages while participating in youth athletics.

By signing, parent or guardian states that their son/ daughter is physically fit to participate in the Brainerd Youth Athletic Association. Print Clearly!

Parent or Guardian Signature: _____

Date Signed: ____/____/____ (Month/ Day/ Year)

Emergency Phone: () _____ - _____