



AAU YOUTH ATHLETE INDIVIDUAL MEMBERSHIP APPLICATION

Use Legal Name

First	Middle	Last
Street Address	City	State
Application Date	Primary Phone	Birth Date (MM/DD/YYYY)
E-Mail Address Required, Membership cards are emailed or may be printed after processing at www.aausports.org		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Club Code (if Known)	Club Name (if Known)	Sport

I certify that this application is correct in every material aspect, including but not limited to my street address and birth date. The Applicant agrees to be bound by the AAU Code, including all AAU Policies, which are available for review on the AAU website at www.aausports.org.

Member's signature or signature of person completing this application	Date
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Parental/Guardian Medical Information and Consent Form

Childs Name:
Age:
Date of Birth:
Gender: Male Female
Address:
Home Telephone Number:
Cell/Work/Other Telephone Number:
Name of Friend or Relative bringing child to activity:
Emergency Contact(s) Information: 1. Name: 2. Relationship to Child: 3. Telephone Number: 1. Name: 2. Relationship to Child: 3. Telephone Number:
Pediatrician/General Practitioner Name: Telephone Number:
Details of any known special dietary requirement/allergies/medical conditions
Any other special needs, requirements, directions, that would be helpful for the coaches to know about:

Anything written on this form will be held in confidence by the coach/trainer. Our coaches/trainers need to know these details in order to meet the specific needs of your child. The coaches/trainers are committed to ensuring that any information gathered in relation to this program meets the specific responsibilities under HIPPA and any other data protection acts. The coaches/trainers will store the above information at The Albany County Recreation Bureau and onsite for a maximum of 12 months or at the expiration of the AAU Membership Year, whichever comes first.

As parent/guardian, I will inform the coaches/trainers of any important changes to my child’s health, medication, or needs and also of any changes to our address or phone numbers.

In the event of illness or injury, having parental responsibility for the above named child, I give permission for medical treatment to be administered where considered necessary by a nominated first aider, or by suitably qualified medical practitioners. If I cannot be contacted and my child should require emergency hospital treatment, I authorize a qualified medical practitioner to provide emergency treatment or medication.

Signature of Parent/Guardian

Print Name

Date