

Official 2026 Salinas Salad Bowl Bobby Sox Softball Player Registration Form

THE SALINAS BOBBY SOX LEAGUE

(Non-refundable Player Insurance Fee of \$25.00 is Part of Registration Fee)

This form is to be completed by the Player's Parent or Legal Guardian

MINI SOX (6U)	.....	Players Born *2019 – 2021	(Eligible if turns 7 on Jan 1 or after)
BOBBY SOX (8U)	.....	Players Born *2017 – 2018	(Eligible if turns 9 on Jan 1 or after)
BOBBY SOX (10U)	.....	Players Born *2015 – 2016	(Eligible if turns 11 on Jan 1 or after)
AMERICAN GIRL (12U)	.....	Players Born *2013 – 2014	(Eligible if turns 13 on Jan 1 or after)
AMERICAN GIRL (14U)	.....	Players Born *2011 – 2012	(Eligible if turns 15 on Jan 1 or after)
AMERICAN GIRL (16U)	.....	Players Born *2009 – 2010	(Eligible if turns 17 on Jan 1 or after)
AMERICAN GIRL (18U)	.....	Players Born *2007 – 2008	(Eligible if turns 19 on Jan 1 or after)

FOR BOARD USE ONLY

List below the two documents used for proof of residency (if required) PRIORITY ORDER PLACEMENT GRP AGE DIVISION TEAM #

1. _____ 2. _____ - - - - -
YES – NO YES – NO YES – NO YES – NO YES – NO YES – NO YES – NO
MANAGER'S DAUGHTER SISTER SAME DIVISION TEAM BUDDY COACH PARENT PITCHER CATCHER ALL STAR SELECT EXPERIENCED PLAYER

PRINT IN INK: Today is: - Sun / Mon / Tue / Wed / Thu / Fri / Sat -- The current time is: _____ AM/PM Today's Date: _____
MUST BE COMPLETED AND SIGNED BY THE PLAYER'S PARENT/GUARDIAN. CHILD LIVES WITH: _____ BOTH PARENTS _____ MOTHER _____ FATHER _____ GRANDPARENTS _____ OTHER

PLAYER'S FIRST NAME LAST NAME -BIRTHDATE- -SCHOOL- -GRADE- SIBLING'S FULL NAME DIVISION
PARENT OR GUARDIAN'S FULL NAME ADDRESS -NUMBER- -STREET- -CITY- -STATE- -ZIP CODE-
() _____ () _____ () _____ () _____
MOTHER'S HOME PHONE MOTHER'S CELL/WORK PHONE FATHER'S HOME PHONE FATHER'S CELL/WORK PHONE
E-MAIL: _____ MOTHER'S OCCUPATION: _____ FATHER'S OCCUPATION: _____

TEAM BUDDY'S NAME -BIRTHDATE--SCHOOL- -GRADE- -ADDRESS- -CITY- -STATE/ZIP- BUDDY'S HOME PHONE

Parent's Consent to Allow Participation in the Salinas Bobby Sox Softball Program and 'Authorization & Consent to Treat a Minor'

My child _____, is hereby given my consent, to physically participate in activities of softball protected under the Salinas Bobby Sox Insurance Program and I assume all risks and hazards. I will provide my child with a glove, safety cleats or athletic shoes, safety sliding gear, and other softball equipment as needed. I realize that the \$25.00 insurance registration is nonrefundable. Note: 6U players must be at least 4 years old and potty trained at start of season. Registered Bobby Sox Players are provided with secondary accident/medical/liability insurance when their name appears on any Salinas Bobby Sox Team Insurance Form. I will pay the League established player participation fee which will help with my child's team's expenses. If my child participates on any tournament team, I realize that I will be responsible for my portion of the financial support of that team. **While participating in softball, I will make certain that my child does not wear jewelry of any type. Before leaving my child at any activity I will make certain a female staff member from their team is present.**

In an emergency, every effort will be made to contact me (us). I, the undersigned parent/guardian of the child, a minor, do hereby authorize/consent to any x-ray, anesthetic, medical, or surgical diagnosis rendered under general or special supervision of any member of the medical/emergency room staff licensed under the provisions of the Medical Practice Act, or a dentist licensed under the provisions of the Dental Practice Act and on the staff at any acute general hospital licensed by the State Department of Public Health. This authorization is given pursuant to the provisions of the civil code in my home state. Consent expires 12/31/2026. Any current physical condition preventing the child's immediate and full physical participation: _____ NO _____ YES

List Below: All medications being taken by your child; all physical restrictions; allergies; asthma; hearing limitations; heart condition; physical impairment; prosthesis; and vision corrections. List all health information known about your child. If no medications are being taken and there are no physical restrictions, write NONE.

FAMILY PHYSICIAN'S FULL NAME () _____
OFFICE PHONE NUMBER

MEDICAL INSURANCE CARRIER NAME (IF NO INSURANCE – WRITE NONE) YOUR POLICY NUMBER () _____
CARRIER PHONE NUMBER

In case of Emergency, when I (we) cannot be reached, contact the following named adults, their relationship to my (our) child and their phone number.

NAME/RELATIONSHIP: _____ EMERGENCY PHONE () _____

NAME/RELATIONSHIP: _____ EMERGENCY PHONE () _____

REG# _____
(To be completed by League Board)

Uniform Size: _____
12U and up: Adult sizes only

Parent or Guardian's Signature