

Netball starts in the Centre



**Alice Springs Netball Association**

PO Box 2479  
Alice Springs NT 0871  
P 08 8952 7392  
E [ntlinknetball@gmail.com](mailto:ntlinknetball@gmail.com)  
W [www.alicespringsnetball.com.au](http://www.alicespringsnetball.com.au)

## THORNY DEVILS REGISTRATION FORM 2024

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Contact Information (If under 18, please give parent/guardian information)

Phone: \_\_\_\_\_ (h) \_\_\_\_\_ (w)

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth (DD/MM/YYYY):        /        /

Please note you may be required to submit a copy of your birth certificate, if selected)

### Next of Kin/Carer/Guardian Details:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ (h) \_\_\_\_\_ (w)

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Players Signature: \_\_\_\_\_ Date:    /        /

### Consent of Parent/Carer/Guardian for nominees under 18 years of age:

I, \_\_\_\_\_, hereby give consent for \_\_\_\_\_ to nominate for an ASNA Team.

Parent/Carer/Guardian Signature: \_\_\_\_\_ Date:    /        /

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### Relevant Medical History:

Do you have a pre-existing medical condition that Thorny Devils volunteers should be aware of (e.g. seizures, asthma etc)?

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If so, do you have a predefined management plan for this condition that Thorny Devils volunteers should be aware of?

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