VALLEY SOCCER CLUB, INC.
REGISTRATION FORM FOR SUMMER RECREATION PROGRAM

Name: _____
(Last) (First) (MI)

Mailing Address: _____

_____Zip_____

Phone: (_____)_____-_____

E-Mail Address: _____

Date of Birth: _____/_____/_____

Sex: ☐ Male ☐ Female

Parents, interested in Coaching?

Name: _____

Contact coach via email (preferred) or phone? (Circle One)

Amount Rec'd: _____ Cash/Chk#:____

Birth Certificate: ___/On file ___/Pending

Registrations must be received by May 31, 2019

Shirt Size:

Youth Sizes:

____ Small (6-8) ____ Medium (10-12) ____ Large (14-16)

Adult Sizes:

___ Small (30-32) ____ Medium (34-36) ___ Large (38-40) ___ X-Large (42-44)

TEAM ASSIGNMENT*

Ages 4-5	Ages 6-7	Age 8-9	Ages 10-14

***NOTE: This program is designed to give area youth the opportunity to play soccer regardless of ability and experience. Players will be assigned to an age group, not a specific coach. Players will be divided on each game day to a team so that everyone will have the maximum playing time. The emphasis is on the overall enjoyment of playing the game. Winning will be de-emphasized. Scores and records will not be kept.**

MEDICAL INFORMATION:

Family Doctor: _____ Phone (____)_____-_____

List any allergies or physical conditions of which a coach should be aware:

_____

_____

Is your child covered by medical insurance: _____

Company Name: _____ Policy #: _____

I/We the undersigned parent/guardian of minor_____
assume all risks and hazards incidental to the participation in the VALLEY SOCCER CLUB YOUTH PROGRAM including transportation to and from activities and I/we do hereby waive, release, absolve the organizers, sponsors, supervisors and participants from any claim arising out of injury to my son or daughter.

As the parent or legal guardian of the above named player, I hereby give my consent for emergency medical care prescribed by a duly licensed doctor of medicine. The care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.

I also understand that I and/or my insurance company (listed above) is responsible for any and all payments for medical services rendered.

Name(s) of Parent/Guardian: _____
(Please PRINT)

Date: _____ _____
(Signature of Parent/Guardian)