

EASTHAMPTON YOUTH SOCCER CLINIC

PARTICIPANT REGISTRATION

Name: _____ DOB: _____

Grade for 2015-16: _____

Parent/Guardian Name: _____

2nd Parent Name: _____

Parent /Guardian Address: _____

2nd Parent Address: _____

Parent's Phone #: _____ Parent Cell Phone #: _____

2nd Parent Phone#: _____ 2nd Parent Cell Phone #: _____

Doctor Name & Phone #: _____

Medical Insurance Co.: _____

Policy #: _____

Person to contact in case of emergency: _____

Their Phone #: _____ Cell Phone #: _____

Allergies: _____

Health Issues: _____

Medication Issues: _____

Shirt size: Youth SM Youth M Youth L

 Adult SM Adult M Adult L

I give permission for my child to participate in the soccer clinics. I hereby certify that my child is in good health and may participate in all games, activities and practices. In case of emergency, I grant my permission for my child to be given emergency treatment at a local hospital.

Parent/Guardian Signature

Date

Return form and check to:

14 Brook St Easthampton, MA 01027