

FAITH FELLOWSHIP SOCCER LEAGUE

SATURDAY MORNINGS IN JULY & AUGUST 10AM – 11:15AM

REGISTRATION FORM

Child's Last Name: _____ First Name: _____ M: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone No. (_____) _____ Birth date: ___/___/___ Gender: _____ Age: _____ Grade Child is entering: _____

Years Soccer Experience: _____ Shirt Size: _____ Church: _____

How did you hear about FFC Soccer League? _____

Family Information

Father: _____ Best number to be contacted at: _____

Mother: _____ Best number to be contacted at: _____

Medical Release Information:

As the parent or legal guardian of the above mentioned player, I hereby give my consent for emergency medical treatment / care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions may be necessary to preserve the life, limb, or well being of my dependant.

Parent / Guardian Printed Name: _____

Parent / Guardian Signature: _____ Date: _____

Insurance Company: _____ ID#: _____ Group #: _____

Child's Doctor: _____ Doctor Phone: _____

Person to notify in case of emergency and phone: _____

List any and all health problems, limitations and allergies: _____

FOR OFFICE USE ONLY

Division: _____

Team: _____