PLAYER REGISTRATION

PLAYER'S INFORMATION

Player's Name:			Birth Date:	Gender: ☐ Female ☐ Male	
Street Address:			City:		
State:	Zip :	Email Address:			

Parent Name:	Home Phone:	Bus Phone:
Email Address:	Cell Phone:	Receive texts? ☐ Yes ☐ No
Parent Name:	Home Phone:	Bus Phone:
Email Address:	Cell Phone:	Receive texts? ☐ Yes ☐ No

In an emergency when parent/guardian cannot be reached, please contact the following:

Name:	Phone 1:	Phone 2:
Name	Phone 1:	Phone 2:

Please list Allergies the player has:		
Please list other medical conditions:		

Physician	Phone 1	Phone 2
Medical/Hospital Insurance Company		Phone
Policy Holder's Name		Policy Number

MEDICAL TREATMENT AUTHORIZATION AND LIABILITY WAIVER

I hereby give my consent to have an athletic trainer, coach, team manager, emergency medical technician, nurse, medical treatment facility, and/or doctor of medicine or dentistry or associated personnel provide the applicant/participant with medical assistance and/or treatment and agree to be financially responsible for the cost of such assistance and/or treatment. I understand treatment for injury will be based on information provided herein. I hereby authorize emergency transportation of the applicant/participant to a medical treatment facility should an individual listed above consider it to be warranted**.** I recognize the possibility of physical injury associated with soccer, and hereby release, discharge, and otherwise indemnify the club, Typhoons F.C., against any claim by or on behalf of the soccer player named above as a result of that player's participation in Typhoons F.C. programs and/or being transported to or from the same, which transportation I hereby authorize.

Signature_____ ***Date*** _____ Relation to player: ☐ Father ☐ Mother ☐ Guardian