PLYMOUTH UNITED FC REGISTRATION

PLEASE MAIL REGISTRATION FORM AND FEE TO:
PLYMOUTH UNITED FC, PO BOX 674 PLYMOUTH, IN 46563
** A Separate form must be filled out for EACH individual player

________________________________ ____________________________________

Player Last Name Player First Name

Date of Birth ____/____/____

Male / Female (Please circle)

Name of Parent/ Guardian (please print) ____

Street Address: ____ City/State/Zip________________________

Home Phone: _____________________________________ Mobile Phone: ___________________________________

Email Address: ____

Emergency Contact: ____ Relationship: ________________________

Emergency Contact Phone: _________________________________ Secondary contact _______________________

MEDICAL AND INSURANCE INFORMATION

INSURANCE DISCLAIMER: I/We, the parents/guardians of (child's name) __________________________________, candidate for a position on a team with the Plymouth Soccer Club/ Plymouth United FC, hereby give my/our approval for my/our child's participation in any and all IYSA and Plymouth Soccer Club activities. I/We assume all risks and hazards incidental to such participation including transportation to and from the activities. I/We do hereby waive. Release, absolve, indemnify, and agree to hold harmless the IYSA/ Plymouth Soccer organizers, offices of the club, advisory board, sponsors, supervisors, coaches, participants, and persons transporting my/our child to or from activities, from any claim arising, or from any injury to my/our child. I/We furthermore understand and agree that any insurance coverage provided through IYSA shall be secondary to any medical insurance that I/We may have, and will only come into effect after my/our personal insurance covered has been exhausted.

MEDICAL RELEASE: As the parent/ legal guardian of (child's name) _______________________________________, I request that in my absence that above named player be admitted to any hospital facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff duly licensed as doctors of medicine of Doctor of Dentistry, or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures, and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above named- player.

Family Physician: _______________________________ Phone: _______________________________

Insurance Carrier: ____________________________________ Policy Number: ________________________________

Tetanus Booster Current? (circle one) YES / NO
Known allergies or allergies to medicine or other medical problems: ____

Signature of Parent/ Guardian: ____ Date signed ______________

Sworn to and subscribed to me on the ______ day of _______, 20__
State of ___________________

Notary Public in and for the State of Indiana
County of __________________ Commission expires _________________

2016/2017 REGISTRATION FEES ARE $110.00 FOR FALL SEASON AND $110.00 FOR SPRING SEASON.