



PLYMOUTH UNITED FC REGISTRATION FORM

PLEASE MAIL 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 ISL 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 ISL/ 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 ISL 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 Doctor of Medicine or 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: _____

2023/2024 REGISTRATION FEES ARE \$135.00 FOR FALL SEASON AND \$135.00 FOR SPRING SEASON.