



TRIANGLE UNITED SOCCER JUNIOR YOUTH DEVELOPMENT ACADEMY REGISTRATION

PLAYER'S INFORMATION

Player's Name		Birth Date	
Street Address		City	State Zip
Email Address			
Parent's Name	Home Phone ()	Cell Phone ()	
Parent's Name	Home Phone ()	Cell Phone ()	
In an emergency when parent/guardian cannot be reached, please contact the following:			
Name	Home Phone ()	Cell Phone ()	
Name	Home Phone ()	Cell Phone ()	
Allergies			
Other Medical Conditions			
Physician	Home Phone ()	Bus Phone ()	
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, their sponsors, the USSF and its affiliated organizations, and the employees and associated personnel of these organizations, against any claim by or on behalf of the soccer player named above as a result of that player's participation in Triangle United Soccer programs and/or being transported to or from the same, which transportation I hereby authorize.*

Signature _____ **Date** _____

(Relation to player: father, mother, guardian) _____