



Prospect Soccer Premier Team Registration Form



Please make checks payable to and remit to:
Prospect Soccer
50 Waterbury Rd. Box 333 (The UPS Store)
Prospect, CT. 06712

Players Information

Players Last Name _____ Players First Name _____

Players Date of Birth ____/____/____ Male Female Height _____ Weight _____ Grade _____

of Seasons Played _____ Last League _____ Last Coach _____

Street Address _____

City _____ Home Phone # _____

Zip Code _____ E-mail Address _____

If Legal Guardian, please check box

Parents or Legal Guardian Information

Father's Name _____ Mother's Name _____

Fathers Phone # _____ Mothers Phone # _____
(Please state cell, home, work, etc.) (Please state cell, home, work, etc.)

Our program is run entirely by volunteers. Please circle from the list below where you'd be willing to help:

Cheerleader _____
Coach Asst. Coach Team Manager Team Parent Summer Camp
Fund Raising Snack Shack Equipment Data Entry

Other (Please Specify): _____

Remarks

(This section is for special requests or general comments)

Emergency Contact Information

Person to notify in an emergency _____ Person's Phone # _____

Doctor to notify in an emergency _____ Doctor's Phone # _____

Please list any medical issues and/or disabilities we should be aware of _____

Waiver and Medical Consent (Minor). Please read and sign

I, the parent/guardian of the registrant, a minor, agree that I and the registrant will abide by the rules of Prospect Soccer and its affiliated organizations and sponsors. I hereby release, discharge and/or otherwise indemnify Prospect Soccer, its affiliated organizations and sponsors and associated personnel, including the owners of the fields and facilities used for its programs, against any claims by or on behalf of the registrant as a result of the registrant's participation in the programs and/or being transported to or from the same, which transportation I hereby authorize.

CONSENT FOR MEDICAL TREATMENT As the parent or legal Guardian of the above-named player, I hereby give consent for emergency medical care prescribed by a licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.

Print Name of Parent or League Guardian _____

Today's Date

Signature of Parent or League Guardian _____

____/____/____

Fee Paid: _____

Check Number: _____

Cash: _____

Received by: _____

Date: _____