LIGHTNING SOCCER CLUB

PLAYER INFORMATION & MEDICAL RELEASE FORM

Player's Name: ____ Phone: ______________________

Address ___________________________________ City____________________ State_____ Zip___________

Birthdate _____/_____/______ U.S. Citizen: Yes _____ No _____ I.D.# _______________________

Parents' Home Phone: (______) ______________________ Parent's Work Phone (______) ___________________

Year of High School Graduation _________ Nearest Major Airport ____

RESPONSIBILITY:
I will conduct myself in a manner respecting the facilities, other players, referees, and the coaching and administrative staff of GSSA and Lightning Soccer Club. Further, I understand that if I am found to be using or in possession of drugs or alcohol or in violation of GSSA and/or hosting facility's rules and regulations that this shall result in my immediate ejection from the program. I also understand and accept the fact that my parents will be responsible for making the necessary travel arrangements and shall bear the financial responsibility for my removal.

____

Signature of Player Date

I have read the above paragraph and fully understand and accept the responsibilities as they are outlined.

____

Signature of Parent/Guardian Date

PARENT'S APPROVAL AND MEDICAL RELEASE:
Recognizing the possibility of physical injury associated with soccer and in consideration for GSSA and Lightning Soccer Club and its affiliates accepting the registrant for its soccer programs and activities (the "Program"), I hereby release, discharge and/or indemnify GSSA and Lightning Soccer Club, its affiliated organizations and sponsors, their employees and associated personnel, including the owners of fields and facilities utilized for the Program, from any claim by or on behalf for the registrant as a result of the registrant's participation in the Program and/or being transported to or from the same, which transportation I hereby authorize. My son/daughter has received a physical examination by a physician and has been found physically capable for participating in the Program. I hereby give my consent to have an athletic trainer and/or doctor of medicine or dentistry provide my son/daughter with medical assistance and/or treatment.

____ (______) ________________________

Signature of Parent/Guardian Date Emergency Phone Number

Medical and/or Hospital Insurance Company: ____

Policy Numbers: ____

Known allergies or other pertinent medical information: ____

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Emergency Phone Number Other Than Parent/Guardian:

____ (_________) _____________________

Name Relation Phone Number

Subscribed and Sworn to Me This _____ Day of _____________, 20_____

Signature ______________________________________ My Commission Expires ______________________

Notary Public