EASTHAMPTON YOUTH SOCCER CLINIC

PARTICIPANT REGISTRATION

Name: _____DOB:_____

Grade for 2020-21: _____
Parent/Guardian Name: _____

2nd Parent Name: _____

Parent /Guardian Address: _____

2nd Parent Address: _____

Parent's Phone #: _____ Parent Cell Phone #: _____

2nd Parent Phone#: _____ 2nd Parent Cell Phone #: _____

Doctor Name & Phone #: _____

Medical Insurance Co.: _____

Policy #: _____

Person to contact in case of emergency: _____

Their Phone #: _____ Cell Phone #: _____

Allergies: _____

Health Issues: _____

Medication Issues: _____

Email Address:_____

I give permission for my child to participate in the soccer clinics. I hereby certify that my child is in good health and may participate in all games, activities and practices. In case of emergency, I grant my permission for my child to be given emergency treatment at a local hospital.

_____

Parent/Guardian Signature Date

Return form and $80 check (or cash) to:
Michael Soucy
14 Brook St
Easthampton, MA 01027