



**Promoting Soccer Excellence and Sportsmanship**

P.O. Box 156, Downingtown, PA 19335

484-888-4711 [www.spiritunited.org](http://www.spiritunited.org)

PLAYER'S LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ SEX: M \_\_\_ F \_\_\_ AGE DIVISION: U- \_\_\_ A \_\_\_ B \_\_\_ JERSEY # \_\_\_\_\_

PLAYER'S ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

E-MAIL

FATHER'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ CELL: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ CELL: \_\_\_\_\_

COACH'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

MEDICAL INSURANCE CARRIER: \_\_\_\_\_

FAMILY DOCTOR'S NAME: \_\_\_\_\_

LIST ANY MEDICAL PROBLEMS: \_\_\_\_\_

EMERGENCY PHONE NUMBERS: \_\_\_\_\_

**PARENT'S APPROVAL AND MEDICAL RELEASE**

Recognizing the possibility of physical injury and in consideration of USSF and its affiliates accepting the registrant for its program and activities (the "Programs"), I, the undersigned parent/guardian of the registrant, a minor, do hereby release, discharge and/or otherwise indemnify the USSF, its affiliated organizations and sponsors, the Spirit United Soccer Club and its affiliated organizations, officers, coaches, referees, managers, board members, tournament hosts and their officials, their employees and associated personnel, including the owners of the fields and facilities utilized for the Programs and/or social events, against any claims by or on behalf of the above-named player as a result of my son's/daughter's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize by the officer, coach or agent(s) of the Spirit United Soccer Club.

My son/daughter has received a physical examination by a physician and has been found physically capable of participating in the Programs. I, the parent/legal guardian of the above-named player, 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 and agree to be responsible financially for the reasonable cost of each assistance and/or treatment. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of my dependent.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_