

**Greenfield Area Soccer Club
Player Registration/Medical Form**

Section I – Player Information

Last Name: _____	First Name: _____	MI: _____
Street: _____	City: _____	Zip: _____
Date of Birth: ___/___/___	Home Phone: _____	
Father's Name: _____	Work Phone: _____	
Mother's Name: _____	Work Phone: _____	
Email: _____	Mobile Phone: _____	

Section II – Medical History and Release

Health Insurance Carrier: _____
Policy Number: _____
Name of Insured: _____ (Please photocopy both sides of your insurance card and attach a copy)
Comments: (please include any information you would like to share with coach in the case of a medical emergency (i.e. allergies, current medications, conditions, etc). _____ _____ _____
<p>I, a parent or guardian of the player named in Section I, who is a participant in the activities of the Greenfield Area Soccer Club (GASC), hereby give my consent and approval to my child's participation in the activities of the GASC. I assume all risks and hazards incidental to my child's participation and hereby release, indemnify, and hold harmless the GASC, Indiana Youth Soccer Association, United States Youth Soccer Association, United States Soccer Association and organizer, supervisors, coaches, managers and agents of those organizations from any liability, claims, and damages arising out of my child's participation in the activities of the GASC. I additionally waive, to the extent not covered by liability insurance, any liability, claims or damages against any person transporting my child to or from said activities. I understand that it is my responsibility to satisfy myself that my child is in satisfactory physical condition to participate in the activities of the GASC. In the event that my child becomes injured or ill during any practice, game, or tournament games while traveling to or from any practice, game or tournament game while a participant in the activities of the GASC, I authorize the child's coach, or his representative, to secure first aid, and/or the services of any physician, dentist or hospital and I agree to assume all financial obligations incurred therewith.</p>
Signature: _____ Date: _____

Subscribed and sworn to before me, a notary public, in and for said county and state this ____ day of _____
State of Indiana,
County of _____ SSN: _____

My Commission expires: _____

Notary Public; _____

County of Residence _____

Printed Name: _____