

For Age Groups U-12,U-14/15,U-16/19 travel teams
Ludington Soccer Club Registration Form---FALL 2008
Registration Fee \$50.00
Deadline 7-31-08!!!

(Soccer Club Use only) Amount Paid _____ Date _____
Check _____ Cash _____ Age level _____

Name _____ DOB _____

Girl _____ Boy _____ Current Grade _____ Main Phone Number _____

Address _____ City _____

State/Zip _____ E-Mail address _____

Parents Name/Phone/Cellular _____

I am interested in COACHING _____ ASSISTING _____ TEAM PARENT _____

*My child has permission to play LUDINGTON SOCCER (LSC) in accordance with the rules of the LSC. I understand and agree that the LSC (including all coaches, officers, assistants, volunteers) shall be held "harmless" and not responsible for any injuries which occur on or off the field. **Players are required to wear shin guards at all practices and games.***

Signature of Parent/Guardian _____ Date _____

SOCCKER MEDICAL RELEASE FORM

I hereby give my permission for any and all medical attention necessary to be administered to my child,

(INSERT CHILD'S NAME)

In the event of accident, injury, sickness, etc, under the direction of the person (s) listed below, until such time as I may be contacted, this release is effective for a period of one year from the date given below. I also assume the responsibility for the payment of any such treatment, including, but not limited to transportation for required treatment.

Parent/Guardian: _____

Address: _____

City/State,Zip: _____

Relationship: _____

Home Phone: _____ Office Phone: _____ Cell Phone: _____

Name of Insurance Company: _____

Agent: _____ Policy # _____ Type: _____

In Case I cannot be reached, any of the following people are designated to act on my behalf:

- | | |
|---|--|
| 1. Coach | 2. Assistant Coach/Manager |
| 3. Team Parent | 4. A League representative where my child is playing |
| 5. Any tournament representative where my child is participating in a US Youth Sanctioned tournament. | |

In case I cannot be reached, please call _____ at _____

Our Physician' Name: _____ Address _____

City/State/Zip: _____ Phone # _____ Hospital _____

Known Allergies: _____

Known Disabilities: _____

Other Important Medical Information: _____

Signature of Parent/Guardian & Date: _____

Subscribed and sworn to before me this _____ Day of _____

NOTARY PUBLIC: _____ My commission expires: _____

Please mail to:
Janice LaPlante
1221 N. Dennis Rd
Ludington, MI 49431
231-843-6191