

**For Age Groups U-6, U-8, U-10 local teams**  
**Ludington Soccer Club Registration Form---FALL 2008**  
**Registration Fee \$30.00**  
**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 \_\_\_\_\_

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**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: \_\_\_\_\_

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