



## SILVER LAKE SOCCER ACADEMY

CLINIC REGISTRATION AND MEDICAL RELEASE - SUMMER 2009

Contact: **Frank Cannizzaro** 718 948-7552 - Clinic Director

Web site: [www.silverlakesoccer.com](http://www.silverlakesoccer.com)

Name: \_\_\_\_\_

Boy

Girl

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Previous Team \_\_\_\_\_

Guardian's Names: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Alternate Contact Person in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

**Clinic Registration Fee:** \$50 for each child

**Make check payable to:** Silver Lake Soccer, Inc.

MEDICAL INFORMATION OF PLAYER: Allergies: \_\_\_\_\_

Medication being taken or other pertinent medical information: \_\_\_\_\_

Family Doctor's name & tel. #: \_\_\_\_\_

Recognizing the possibility of physical injury associated with soccer and in consideration for SLA and its affiliated groups the registrant for its soccer program and activities (the "Programs"), I hereby release, discharge and/or indemnify SLA, its affiliated organizations and sponsors, their employees and associated personnel, including the owners of fields and facilities utilized for the Programs, against any claim by or behalf of the registrant's participation in the Programs. My child has received a physical examination by a physician and has been found physically capable of participating in the Programs.

Therefore, I grant the Clinic Director permission to act as my surrogate for my child in the area of obtaining medical treatment by a doctor of medicine or dentistry. I also assume the financial responsibility for any medical treatment for my child.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_