



SILVER LAKE SOCCER ACADEMY

CLINIC REGISTRATION AND MEDICAL RELEASE - SUMMER 2010

CONTACT: Frank Cannizzaro 718 948-7552 - Clinic Director

E-MAIL: F.CANNIZZARO@ATT.NET

Web site: www.silverlakesoccer.com

Name: _____ Boy Girl

Address: _____ Zip Code: _____

Phone #: _____ Date of Birth: _____ Previous Team _____

Child's Skill Level: Beginner _____ Intermediate _____ Advanced _____ Not Sure _____

Guardian's Names: _____ E-Mail Address: _____

Alternate Contact Person in case of emergency: _____ Phone: _____

Clinic Registration Fee: \$75 for each child

Make check payable to: Silver Lake Soccer, Inc.

Mail form and check to: Frank Cannizzaro 697 Rensselaer Avenue Staten Island, NY 10312

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: _____

NOTE: PLEASE SUBMIT A FORM FOR EACH CHILD ATTENDING CLINIC.