



**Academy Player Development Program
REGISTRATION FORM**

PLAYER/PARENT INFORMATION

Player's Legal Name _____ Date of Birth _____

Parent Names: _____

Address _____

City, State, Zip Code _____

Home Phone # _____

Father's Cell Phone # _____ Mother's Cell Phone # _____

Email Address _____

Academy T-Shirt size _____ (included)

Non Refundable Payment of \$150 is due upon registration. You may pay online during online registration or pay by check. Please make checks payable to Discoveries Soccer Club. Refunds will only be considered for medical injury to the player.

Mail paperwork, copy of insurance card – front and back, 1 copy of player birth certificate and payment to:

**Beth Balint
1685 Mary Ellen Dr, Fort Mill, SC 29708.**

AGREEMENT OF INDEMNIFICATION:

I, the parent/guardian of the registrant, a minor, agree that the registrant and I will abide by the rules of the Discoveries Soccer Club, its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration for Discoveries Soccer Club accepting the registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify Discoveries Soccer Club, its affiliated organizations and sponsors, their employees and facilities utilized for the Programs, the City of Rock Hill and Rock Hill School District #3, against any claim by or on behalf of the registrant as a result of the registrant's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize.

Parent

Or Guardian Name _____
(PLEASE PRINT)

Signature _____ Date _____

Medical Information

Insurance

Primary Insurance Carrier _____ Name on Account _____

Policy Number _____

Known Allergies _____

Emergency Contact (other than parent or guardian)

Name _____ Phone _____

Doctor to notify in an emergency _____

Phone number _____

Consent for Medical Treatment:

As the parent or legal guardian of the registrant, I hereby give my consent for medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life and/or limb of my dependent. I also assume the financial responsibility for any medical treatment for my child.

Signature of Parent/Guardian: _____ Date: _____

Subscribed and sworn to me this _____ Day of _____ 20_____

Notary Signature _____