



CLAY COUNTY SOCCER CLUB

3 V 3 SUMMER LEAGUE

PLAYER 1 NAME					M () F ()	PAID ()
EMAIL					PARENT OR GUARDIAN SIGNATURE	
D.O.B					PLEASE READ RELEASE BELOW	
AGE	U9 ()	U10 ()	U11 ()	U12 ()	U13 ()	

PLAYER 2 NAME					M () F ()	PAID ()
EMAIL					PARENT OR GUARDIAN SIGNATURE	
D.O.B					PLEASE READ RELEASE BELOW	
AGE	U9 ()	U10 ()	U11 ()	U12 ()	U13 ()	

PLAYER 3 NAME					M () F ()	PAID ()
EMAIL					PARENT OR GUARDIAN SIGNATURE	
D.O.B					PLEASE READ RELEASE BELOW	
AGE	U9 ()	U10 ()	U11 ()	U12 ()	U13 ()	

PLAYER 4 NAME					M () F ()	PAID ()
EMAIL					PARENT OR GUARDIAN SIGNATURE	
D.O.B					PLEASE READ RELEASE BELOW	
AGE	U9 ()	U10 ()	U11 ()	U12 ()	U13 ()	

PLAYER 5 NAME					M () F ()	PAID ()
EMAIL					PARENT OR GUARDIAN SIGNATURE	
D.O.B					PLEASE READ RELEASE BELOW	
AGE	U9 ()	U10 ()	U11 ()	U12 ()	U13 ()	

PLAYER 6 NAME					M () F ()	PAID ()
EMAIL					PARENT OR GUARDIAN SIGNATURE	
D.O.B					PLEASE READ RELEASE BELOW	
AGE	U9 ()	U10 ()	U11 ()	U12 ()	U13 ()	

As the parent/legal guardian of the above named player, I request that in my absence the above named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff duly licensed as Doctors of Medicine or Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures treatment procedures, operative procedures and any treatment of the above named minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above named player.

I recognize the possibility of physical injury associated with soccer, and hereby release, discharge, and otherwise indemnify Clay County Soccer Club, their sponsors, FYSA, US youth Soccer Association, and its affiliated organizations, and the employees and associated personnel of these organizations, against any claim by or on behalf of the soccer player mentioned above