



Academy Registration Form

Amount Paid: _____

Reg Date: ____/____/____

Player Information:

First Name Last Name Birthdate ____/____/____ M / F

Street Address City Zip Code

School Grade

Parent/Guardian Information:

First Name Last Name Relationship

Email (_____) Cell Phone (_____) Home Phone

Address: Check here if same as player (____)

Street Address City Zip Code

PARENTAL PERMISSION, EMERGENCY CONTACT INFO & LIABILITY WAIVER *(to be completed by parents)*

As parent or legal guardian of _____, I hereby give my consent for his/her participation with the Heritage Soccer Club Academy.

I, the undersigned parent or legal guardian of the above player, a minor, for myself and on behalf of the above player, acknowledge that participation in soccer necessarily involves contact with considerable force, and risk of severe, permanent physical injury including bruises, scrapes, strained, sprained or torn muscles, tendons or ligaments, broken bones, and more serious injuries. We understand these risks of the sport and with that knowledge willingly and voluntarily accept and assume all such risks or injury.

I hereby release and hold harmless Heritage Soccer Club ("HSC"), Soccer Training Solutions LLC, their coaches, trainers, assistant coaches, board members, volunteers, officials, sponsors and other representatives and any and all owners, lessors, lessees or other persons or entities allowing, permitting or authorizing the use of facilities by HSC, and the agents, employees, officers and directors of said persons or entities from any and all claims, demands, costs, expenses and compensation arising out of or in any way related to any injury or other damage that may result to said participant while participating in or present at any HSC-sponsored event, including any physical or other injury caused by the negligence of any person or entity described above.

I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment.

Signature of Parent or Legal Guardian: _____ **Date** _____

Parent/Legal Guardian Name: _____

Alternate Contact Name: _____ **Phone** _____

Is your son/daughter presently covered by a Medical/Hospital Insurance policy? Yes ____ No ____

Health Insurance Company _____ **Policy #** _____

Physician's Name _____ **Office Phone** _____