



PARENT AGREEMENT WITH **WEST HEMPSTEAD CHIEFS SOCCER CLUB**

I, THE PARENT OF _____, GIVE APPROVAL FOR HIS/HER PARTICIPATION IN ANY AND ALL ACTIVITIES OF THE CLUB. ACKNOWLEDGING THAT THE RESPONSIBILITY FOR DETERMINING THE CHILD'S PHYSICAL FITNESS TO PARTICIPATE IS MINE AND MINE ALONE. I HEREBY REPRESENT AND WARRANT THAT THE CHILD FOR WHOM THIS REGISTRATION IS SUBMITTED IS PHYSICALLY AND OTHERWISE FIT IN ALL ASPECTS TO FULLY PARTICIPATE. I ACKNOWLEDGE THAT THE RESPONSIBILITY IS ALWAYS MINE TO NOTIFY THE CHILD'S COACH OR AN OFFICER OF THE CLUB IF THERE ARE ANY CHANGES IN HIS/HER STATUS, UNDERSTANDING THAT SUCH INFORMATION MAY BE USED IN DETERMINING THE CHILD'S CONTINUED ELIGIBILITY TO PLAY. I DO HEREBY RELEASE, ABSOLVE, INDEMNIFY AND HOLD HARMLESS THE **WEST HEMPSTEAD CHIEFS SOCCER CLUB**, THE OFFICERS, ORGANIZERS, SPONSORS, SUPERVISORS AND COACHES AND OTHERS APPOINTED BY THEM. I LIKewise, RELEASE FROM RESPONSIBILITY ANY PERSON TRANSPORTING OUR CHILD TO AND FROM RELATED ACTIVITIES. ALSO, AT LEAST ONE PARENT IS ENCOURAGED TO ATTEND EACH GAME.

I HAVE READ AND WILL ABIDE BY THE ABOVE AS WELL AS THE GENERAL RULES OF THE **WEST HEMPSTEAD CHIEFS SOCCER CLUB**. I ALSO UNDERSTAND THIS FORM WILL NOT BE ACCEPTED WITHOUT PAYMENT UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

NOTE: SHINGUARDS ARE REQUIRED FOR ALL GAMES

PARENT'S SIGNATURE: _____ DATE: _____

E-MAIL ADDRESS: _____

MEDICAL INFORMATION

I HEREBY GIVE MY AUTHORIZATION AND CONSENT TO ANY SUPERVISING REPRESENTATIVE OF THE **WEST HEMPSTEAD CHIEFS SOCCER CLUB** TO CAUSE MEDICAL ATTENTION TO BE

ADMINISTERED BY MY CHILD _____ IN THE EVENT OF AN ACCIDENT, INJURY, SICKNESS OR OTHER MEDICAL PROBLEMS. THE AUTHORIZATION AND CONSENT FORM SHALL TAKE PLACE IMMEDIATELY AND SHALL CONTINUE THROUGH THE CURRENT SEASON. I AGREE THAT I WILL SOLELY AND PERSONALLY BE RESPONSIBLE FOR PAYMENT OF SUCH MEDICAL ATTENTION.

MY ADDRESS IS: _____

PHONE: (HOME) _____ PHONE: (OFFICE) _____

IN THE EVENT I CANNOT BE REACHED PLEASE CONTACT:

NAME: _____ PHONE: _____

PHYSICIAN'S NAME: _____ PHONE: _____

ALLERGIES: _____ MEDICATIONS: _____

IS THERE ANYTHING WE SHOULD KNOW ABOUT YOUR CHILD TO HELP THEM ADJUST TO OUR PROGRAM? PLEASE USE THE SPACE BELOW TO COMMENT.

PARENT'S SIGNATURE: _____ DATE: _____

WEST HEMPSTEAD CHIEFS SOCCER CLUB
P.O. BOX 494
WEST HEMPSTEAD, NY 11552
(516) 733-4409
WWW.WHCHIEFS.COM



FOUR YEAR OLD PROGRAM

NAME: _____ ☐ BOY ☐ GIRL

ADDRESS: _____ AGE _____ GRADE _____

_____ DATE OF BIRTH ____/____/____

PHONE: _____ SCHOOL: _____

**FEES: \$45.00 / INCLUDES SHIRT AND SOCCER BALL.
\$35.00 IF YOU HAVE BALL AND SHIRT FROM FALL
NO FAMILY DISCOUNTS FOR 4 YEAR OLD PROGRAM**

ALL FEES ARE NON-REFUNDABLE

FORMS MUST BE RECEIVED BY JANUARY 15, 2004.

**VOLUNTEERS: WE ARE ALWAYS IN NEED OF VOLUNTEERS. OUR ORGANIZATION WILL NOT SUCCEED
UNLESS WE HAVE THE FULL COOPERATION OF ALL OF OUR FAMILIES. TRAINING IS AVAILABLE FOR COACHES.**

PLEASE CHECK ONE

☐ COACH _____ (name) SHIRT SIZE: _____

☐ ASST. COACH _____ (name) SHIRT SIZE: _____

☐ FIELD LINING _____ (name)

☐ FUND RAISING ☐ SPONSOR ☐ OTHER _____

UNIFORM ORDER SHEET

SHIRT ONLY

☐ **YS** ☐ **YM** ☐ **YL**