BOB SMITH SOCCER ACADEMY
PARENTAL WAIVER FORM

Please Print or Type Requested Information

Player Date of Birth:			
Player's Last Name:		First Name:	
Father's Name:		Mother's Name:	
Father's Email:		Mother's Email:	
Father's Cell:		Mother's Cell:	
Father's Home Telephone:		Mother's Home Telephone:	
Street Address:		City:	Zip:

Medical Information

Allergies	
Other Medical Conditions	

CONSENT/WAIVER STATEMENT

I, the Parent/Guardian of the registrant, a minor, hereby consent and allow the participation of the registrant in the Bob Smith Soccer Academy at Robbinsville Fieldhouse. I agree that I the registrant will abide by the rules of USSF, USYSA, NJ Youth Soccer, US Club Soccer and their affiliated organizations, Bob Smith Soccer Academy, Robbinsville Fieldhouse LLC and their sponsors. I recognize the possibility of physical injury associated with soccer to the registrant and in consideration for the Bob Smith Soccer Academy accepting the registrant for participation in its programs, I for myself and the registrant hereby release, discharge, indemnify and hold harmless Bob Smith Soccer Academy, USSF, USYSA, NJ Youth Soccer, US Club Soccer, Robbinsville Fieldhouse LLC, and their affiliated organizations and sponsors, their employees and agents, against any claim by or on behalf of myself or the registrant resulting from the registrant's participation in the tryouts. I further affirm and agree that I or another adult responsible for the registrant shall be present at all times of participation by registrant, and shall be available in the event medical treatment for the registrant becomes necessary in the event of an injury during competition. I further authorize any coach or trainer of Bob Smith Soccer Academy seek medical treatment for the registrant in the event of an injury during competition when I or another parent or guardian of the registrant is not present and cannot be promptly contacted to authorize such treatment. I accept full financial responsibility for any such necessary medical treatment. I accept full financial responsibility for any such necessary medical treatment.

Name of Parent/Legal Guardian (please type or print):

_____

Signature: _____ **Date:** _____