



Fall Registration Form

Fall 2011
Town of
Greenfield
Soccer

The program will take place at the Middle Grove Town Park in September 12th through October 21st, 2011. This program consists of approximately six weeks of games between our Town of Greenfield teams.

Registration Fee \$15 per child (Make Checks Payable to the **TOWN OF GREENFIELD**)
(\$20 if you register after Sept. 6th, 2011)

Child's Name _____ Date of Birth _____

Age _____ years Grade Entering in September 2011 _____

Desired Division (Circle One)

Division 1 (5 and 6 years) Division 2 (7 and 8 years) Division 3 (9, 10, 11, and 12 years)

T-Shirt Size (Circle One)

6-8 10-12 14-16 Adult Small Adult Medium Adult Large Adult XL

Email _____

Name of Parents/Guardians (Print) _____ Telephone _____

As parent or legal guardian, I give full consent for the above named participant in the Greenfield Soccer Program. To my knowledge, he/she has no known disability, illness, or disease which may endanger his/her safety or the safety of others. I understand that the program is provided for a minimum charge for the education of the youth. I further release the town of Greenfield, its officers, officials, property owners, coaches, referees, any volunteers, and other program participants or their families from liability as a result of personal and/or property damage incurred while participating in the soccer program

Signature of parent or legal guardian _____ Date _____

Before Sept. 6, mail the Fee and Registration and Medical Authorization Forms to:

**Town of Greenfield Recreation Director
PO Box 10
Greenfield Center, NY 12833**

Games being the week of September 12th

Coaches and Assistant Coaches are always needed. A shortage in coaches will lead to larger team sizes and less playing time for each child. Please volunteer if you can! It's a great way to spend time with your child!

(Circle One) I am willing to Coach a team.
I am willing to be an Assistant Coach.
Sorry, I am unable to coach this year.

Name of Volunteer _____

AUTHORIZATION FOR EMERGENCY TREATMENT OF MINORS

Name of Minor _____ Birthdate _____

I, Being the parent or legal guardian of the above minor do hereby appoint
The Town of Greenfield Soccer Program
(OR) Authorized Physicians of Hospital
to act on my behalf in authorizing emergency medical, dental, or surgical care and
hospitalization for the above named minor during the period(s) of my absence.

This document will be presented to a physician, dentist, or appropriate hospital representative at such time
as emergency, dental, surgical or hospitalization may be required.

Parent/ Guardian

Name (print) _____ (Signature) _____

Address _____

City _____ State _____ Zip _____

Phone _____ Date _____

Witness

Name (print) _____ (Signature) _____

Date _____

HOSPITALIZATION COVERAGE FOR THE ABOVE NAMED MINOR

Name of Insurance Company _____

Group Number _____ Member Number _____

Family Physician (Name) _____ Phone _____

Known Allergies _____

Last Tetanus Toxoid Booster _____

Other Pertinent Medical Information (i.e. glasses, contact lenses) _____
