

FALL 2008 TECHNICAL SKILL SPECIFIC TRAINING SESSIONS
PLAYER REGISTRATION AND INJURY WAIVER FORM

PLAYER'S NAME _____ AGE _____ SCHOOL GRADE _____

Please check session attending. \$100 per session. Sessions are limited to 8 maximum

Friday Program- 5 Sessions

November 7th, 14th, 21st, December 5th, 12th

- ___ 4:00pm to 5:00pm- Heading (ages 9-11)
- ___ 5:00pm to 6:00pm- Dribbling (ages 9-11)
- ___ 6:00pm to 7:00pm- Heading (ages 12-14)
- ___ 7:00pm to 8:00pm- Dribbling (ages 12-14)

Sunday Program- 5 Sessions

November 2nd, 9th, 16th, 23rd, December 7th

- ___ 8:00am to 9:00am- Striking the Ball (Shooting) (ages 9-11)
- ___ 9:00am to 10:00am- Passing and Rec. (ages 9-11)
- ___ 10:00am to 11:00am-Striking the Ball(Shooting)(ages 12-14)
- ___ 11:00am to 12:00pm- Passing and Rec. (ages 12-14)
- ___ 2:00pm to 3:00pm- Striking the Ball (Shooting) (ages 9-11)
- ___ 3:00pm to 4:00pm- Passing and Rec. (ages 9-11)
- ___ 4:00pm to 5:00pm- Striking the Ball (Shooting) (ages 12-14)
- ___ 5:00pm to 6:00pm- Passing and Rec. (ages 12-14)

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PARENT / GUARDIAN NAME _____

HOME PHONE (_____) _____ WORK PHONE (_____) _____ CELL PHONE (_____) _____

EMAIL ADDRESS _____

IN AN EMERGENCY WHEN PARENT / GUARDIAN CANNOT BE REACHED, PLEASE CONTACT

NAME _____ REALATIONSHIP TO PLAYER _____

HOME PHONE (_____) _____ WORK PHONE (_____) _____ CELL PHONE (_____) _____

Does your daughter/son have any medical conditions that might occur or affect them during the training?
(physical or mental disabilities, allergies or asthma, taking medications, any other problems)

INJURY WAIVER

I, the Parent / Guardian of the player named herein, acknowledge participation in the sport of soccer, as many sports, may result in injury. The undersigned Parent / Guardian therefore releases FC Las Vegas, its teams, officers, coaches and players from responsibility for any injury to my child during the sessions:

Name of Parent / Guardian (Please Print)

Signature of Parent / Guardian

Date

CONSENT FOR MEDICAL TREATMENT (MINOR)

I, _____, hereby grant permission to FC Las Vegas Staff to render to my daughter/son any preventative measures, basic first-aid acute injury treatment or emergency treatment deemed reasonable and necessary for my daughter/son during the camp. I also grant permission for the staff to make appropriate medical referral to a physician of choice in the event of such injury or illness occurs during the sessions.

Also, when necessary for executing such a case, I grant permission for hospitalization at an accredited hospital, as deemed necessary by the attending physician.

Signature of Parent / Guardian

Date

Please send complete registration form and check, made payable to FC Las Vegas, to:

FC Las Vegas
7345 S Durango Dr #B107-327
Las Vegas, NV 89113

For more information email todd.abdalla@fclasvegas.com or call 702-528-4230