



Tri-City Football Club
 SCO-1 Sector 68, Mohali
 +91 90414 60130
 tricityconnectpvt@gmail.com



Registration & Medical/Liability Waiver Form

Player Name: _____
 (First) (Middle) (Last)

Address: _____

Date of Birth: _____ Age: _____

School/College _____ Standard: _____

Home Phone: _____ Player Cell Phone: _____

Favorite Football Position: _____ Years of Football Played: _____

How did you hear about Tri-City Football Club? (Circle one):
 Friend/Family Facebook Instagram Website

Parent Name (father): _____ Cell Phone: _____

Parent Name (mother): _____ Cell Phone: _____

**In an emergency when parent/guardian cannot be reached, please provide other contact:
 Name: _____ Number: _____

** Does your child have any medical condition(s) and or allergies? YES NO (Please circle)
 If yes, please explain:

Recognizing the possibility of injury or illness, and in consideration for Tri-City Connect accepting my son/daughter as a player in the football programs, I consent to my son/daughter participating in the Tri-City Football Club. Further, I hereby release, discharge, and otherwise indemnify Tri-City Connect/Tri-City Football Club, its member organizations and sponsors, their employees, associated personnel, and volunteers, including the owner of fields and facilities utilized for the games and/or practices against any claim by or on behalf of my player son/daughter. Because of my son's/daughter's participation in the club and/or being transported to or from the club activities, I hereby authorize the transportation of my son/daughter to or from events, as necessary.

I have provided written notice, which is submitted in conjunction with this release, setting forth any specific issue, condition, or ailment, in addition to what is specified above, that my child has or that may impact my child's participation in the club. I give my consent to have an athletic trainer and/or licensed medical doctor or dentist provide my son/daughter with medical assistance and/or treatment and agree to be financially responsible for the cost of any such assistance and/or treatment.

Parent Signature: _____ Date: _____

Parent Printed Name: _____