ONEGOAL FUTBOL
Our goal ... developing players!

SYDNEY GIRLS FOOTBALL ACADEMY

Registration Form

Player Name: ____________________________ Surname: ______________________________Date Of Birth: _____/_____/_________

Parent / Guardian: ____Mobile: ______________________________________

Email: ____Emergency Contact: _____________________________________

Age Group: Mini (5 – 8) Junior (9 – 11) Youth (12 – 17) (Please Circle)

School Holiday Clinic: (Week 1) (Week 2) WINMALEE (Please Circle)

Name and Address of Family Doctor (if applicable): ____

Medicare No: ______________________________Private Health Care Details (if applicable): ________________________________

Health Care Card No: ____

Ambulance Cover: Yes No Number: ____

Does your child suffer from any of the following?

◯ Epilepsy ◯ Heart Conditions ◯ Asthma ◯ Diabetes ◯ Blackouts ◯ Migraines ◯ Other

____

Allergies to: Penicillin ___________________________________Other Medication _____________________________________

What special care is recommended?

____

Is your child on any form of ongoing medication, if so please state?

DIRECT DEBIT / EFT:

Bank: - Commonwealth
Account Name: - One Goal Futbol
BSB: - 062-601
Account Number - 1043 2390

When making PAYMENT ELECTRONICALLY please use PLAYERS SURNAME AND FIRST INITIAL as the PAYMENT REFERENCE.

CASH PAYMENT: MUST BE MADE ON FIRST DAY OF PARTICIPATION IN AN ENVELOPE WITH THE CORRECT AMOUNT OWING

WAIVER

The undersigned in their capacity as parent/guardian of ____ (insert participants name) acknowledges that they have read and understood the Terms & Conditions stated by One Goal Futbol and that this project is organized and managed by Staff, and hereby waives any claim against One Goal Futbol, and their affiliated companies in connection with the One Goal Futbol project he is being enrolled to.

CONSENT TO MEDICAL ATTENTION

Where the Coach or Club Management is unable to contact me, or it is impracticable to contact me, I hereby give permission to the Coach or Club Management to seek treatment for my child at a hospital, or to call a Doctor and/or ambulance and/or dentist during an emergency and agree to pay all relevant costs involved.

Name of Parent/Guardian ____

Signature ____ Date ____