Registration Form

Player Name: _____ **Surname:** _____**Date Of Birth:** ____/____/_____

Parent / Guardian: _____**Mobile:** _____

Email: _____**Emergency Contact:** _____

Age Group: Mini (6 – 8) Junior (9 – 12) Youth (13 – 14) (Please Circle)

Start Time: 9:00am – 12:00pm School Holiday Clinic: (Week 1) WINMALEE April 12th, 13th, 14th Fees: $180 (Please Circle)

Start Time: 9:00am – 1:00pm School Holiday Clinic: (Week 2) RYDALMERE April 19th, 20th, 21st Fees: $270 (Please Circle)

***Rydalmere clinic pizza lunch provided (please advise any dietary requirements)** _____

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** _____