RHEA COUNTY
COMMUNITY CENTER

SOCCER REGISTRATION

Name of Child: ________________________________ Nickname: ________________
Gender: ______ Age: __________ Grade: _________ Birth Date: ____/____/_____
Address: ____
City: ________________________ State: _________ Zip Code: ______________
Parent/Guardian Name: ____
Home Phone: ______________________Work Phone: ________________________
TEXT # for Parent:________________________ Email Address:______________________

Please check appropriate section:

____U6(4-5yr old)____U8(6-7yr old)____U10(8-9yr old)____U12(10-11yr old)____U14(12-13yr old)

Siblings participating: 1) _______________ 2) ________________ 3) ______________

How many seasons has your child played soccer? ________

I am NOT available for practice on (circle): Monday Tuesday Thursday

JERSEY SIZE (circle one): YS YM YL AS AM AL AXL AXXL

PERMISSION REQUEST

Name of Child: ________________________________ Birth Date: ________________________

I hereby release RC3 from any and all liability of any kind of personal injury or property damage due to participation in this program. I certify that my child is in good health and is able to participate in all activities. If any attention is required for illness or injury, I give my permission to a staff member for such care. I give consent for my child to be photographed or videotaped and for those images to be used by the RC3 in the future. I understand that the RC3 will attempt to make up time lost due to bad weather, however if time cannot be made up I understand that no refund will be provided.

_____________________________ _____________________
Signature of Parent/Guardian Date

The parent(s) guardian(s) authorize the RC3 to obtain immediate medical care and consents to the hospitalization of, the performance of necessary diagnostic test upon, the use of surgery on, and/or the administration of drugs to his/her child or ward if an emergency occurs when he/she cannot be located immediately. It is also understood that this agreement covers only those situations which are true emergencies and only when he/she cannot be reached. The parent(s)/Guardian(s) understand that the provider will make every effort to contact them and/or their designated emergency contacts.

Please complete the following:

1. I/we will be responsible for payment of medical expenses.
2. Medical treatment costs are covered by: Insurance Company: __________________Policy #: _______________
   Child's Physician or Clinic Attended: ___________________________

_____________________________ _____________________
Signature of Parent/Guardian Date

COACHES NEEDED: _____Coach _____Assistant Coach _____Father will help _____Mother will help

SOCCER FEE*

*Financial assistance is available. Applications are available at the front desk.

Fall Soccer (ages 4-13) Members ……………..$55.00
Fall Soccer (ages 4-13) Potential-Member ……$90.00

For Office Use Only
Date:____________
Amount Paid:_________
Staff Initials:_________

Special requests will be considered but are not guaranteed.

STUDENT-ATHLETE & PARENT/LEGAL GUARDIAN CONCUSSION STATEMENT

According to the Centers for Disease Control and Prevention, a concussion is a type of traumatic brain injury that changes the way the brain normally works. Most concussions occur without loss of consciousness. Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. The new concussion law is an opportunity to make playing sports safer for Tennessee's young athletes. For more information, visit: http://tn.gov/health --> Preventing Brain Injury

This form must be signed and returned to Rc3 prior to participation in practice or play. Rc3 strives to keep children and adults safe in all of our programs. Coaches will follow concussion protocols during practices and games.

Student-Athlete Name: ____

Parent/Legal Guardian Name(s): ____

After reading the information sheet, I am aware of the following information:

Student-Athlete Initials		Parent/Legal Guardian Initials
	A concussion is a brain injury which should be reported to my parents, my coach(es) or a medical professional if one is available.	
	A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.	
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	
	I will/my child will need written permission from a health care provider* to return to play or practice after a concussion.	
	Most concussions take days or weeks to get better. A more serious concussion can last for months or longer.	
	After a bump, blow or jolt to the head or body an athlete should receive immediate medical attention if there are any danger signs such as loss of consciousness, repeated vomiting or a headache that gets worse.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before the concussion symptoms go away.	
	Sometimes repeat concussion can cause serious and long-lasting problems and even death.	
	I have read the concussion symptoms on the Concussion Information Sheet.	

* "Health care provider" means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training, or a physician assistant with concussion training who is a member of a health care team supervised by a Tennessee licensed medical doctor or osteopathic physician.

______________________________________ ____________________

Signature of Student-Athlete Date

______________________________________ ____________________

Signature of Parent/Legal Guardian Date