



# Council Bluffs Futbol Club

## 2009 / 2010–Club Registration Form

[www.cbsoccer.org](http://www.cbsoccer.org)

Team Name: \_\_\_\_\_

Player Number: \_\_\_\_\_ or TBD

Returning CBFC Player Y / N

Copy of Birth Certificate Y / N

Paid \_\_\_\_\_

### Player's Information:

First Name:		Middle	Last Name:	
Date of Birth		Gender (M/F)	Player's Email Address	
Doctor's Name			Doctor's Phone Number	

### Parent/Guardian Information:

Name		Relationship to Player	
Address			
City, State ZIP			
Phone	Phone 2	Email Address	
Mother's Maiden Name	Mother's Date of Birth		
		/ /	

### Additional Contact Information: (Optional)

Name		Relationship to Player	
Address			
City, State ZIP			
Phone	Phone 2	Email Address	

### Consent to Participate

I give my consent for my child to participate in the activities of the Council Bluffs Futbol Club (CBFC). My child and I have read and agree to abide by the code of conduct and all other rules imposed by CBFC. As the parent/guardian of the above child, I acknowledge the risks of injury with participation, and in consideration of my child being allowed to participate in the activities of CBFC, assume all risk associated with participation and for myself and minor child, RELEASE and FOREVER DISCHARGE the CBFC Soccer Club from any and all claims, demands, and actions of any and every nature whatsoever.

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_



# Council Bluffs Futbol Club

2009 / 2010

## Medical Release Form

[www.cbSoccer.org](http://www.cbSoccer.org)

Team Name:

Coach:

Age: U\_\_ Boys / Girls

Name		Relationship to Player	
Address			
City, State ZIP			
Phone	Phone 2	Email Address	
Known allergies including any allergies to medicine:			
Any other medical issues which should be noted:			

### Medical Release and Liability Waiver

As the parent/legal guardian of the above named player request that in my absence the above named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_