

# Monticello United Soccer Club Registration Form

Monticello United Soccer Club  
P.O. Box 7214  
Charlottesville, VA 22906  
(434) 974-GOAL (4625)

NAME OF COACH:	TEAM FEE:	SEASON: FALL _____ SPRING _____	
LAST NAME:	FIRST NAME:	M.I.	NICKNAME:
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:
MALE: ___ FEMALE ___	DATE OF BIRTH:	PRIMARY EMAIL ADDRESS:	
FATHER'S NAME:	WORK PHONE:	HOME PHONE:	CELL PHONE:
MOTHER'S NAME:	WORK PHONE:	HOME PHONE:	CELL PHONE:

\*\*\* Please submit signed application form and fee together

### CONSENT TO PLAY & EMERGENCY MEDICAL TREATMENT AUTHORIZATION:

I, the parent of \_\_\_\_\_, hereby give my approval for his/her participation in Monticello United Soccer Club activities. I assume all risk and hazards incidental to such participation, including transportation to and from activities: and I do hereby waive, release, absolve, indemnify, and agree to hold harmless the Monticello United Soccer Club, and its representatives for any claim arising out of injury to my child, whether the result of negligence or for any other cause.

I will furnish a certified birth certificate for the above named child upon request by Club Officials. I authorize the coach, or a representative of Monticello United Soccer Club, to present my child, \_\_\_\_\_, for emergency medical treatment by a physician, surgeon or hospital licensed by the Commonwealth of Virginia.

Signed \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_ Ins. # \_\_\_\_\_

Medical Conditions/Allergies \_\_\_\_\_

REFUND POLICY:	WITHDRAWAL BETWEEN JUNE 15 - JUNE 30	REFUND MINUS \$50.00
	WITHDRAWAL BETWEEN JULY 1 - JULY 14	REFUND 1/2 TOTAL FEE
	WITHDRAWAL AFTER JULY 14	NO REFUND

OFFICE USE: Fee Received \_\_\_\_\_  
Date Received \_\_\_\_\_  
Method/Pay \_\_\_\_\_