Norrisville Recreation Council Registration Form

Program: _____

PLAYER/PARTICIPANT INFORMATION

Name: _____

Address: _____

Home Phone:_____ Cell: _____

Email: _____

DOB: _____/_____/_____

Age Group: (circle one) 5/6 7/8 9/10 11/12 13/15

Other: _____

***Uniform Size*:**

Shirt Size (circle one): YS YM YL AS AM AL AXL

Other: _____

Sock Size (Soccer Only): YS YM YL AS AM AL

Parent/Guardian Names: _____

Emergency Contact: _____

Are there physical conditions or allergies of which the coach/administrator should be aware? _____

_____

Are special accommodations needed? _____

RELEASE OF LIABILITY

I do hereby expressly agree to release Harford County, Maryland, a body corporate and politic of the State of Maryland, and its elected and appointed officials, agents, officers, and employees, and the Norrisville Recreation Council from all liability arising from any harm or injury, including death, sustained by me/my child while participating in this program.

In accordance to Maryland law, I understand that information on Youth Sports Concussion and Head Injuries is available at http://www.cdc.gov/headsup/youthsports/index.html and information on Sudden Cardiac Arrest at http://www.nhlbi.nih.gov/health/health-topics/topics/scda/ .

Participant/Parental Agreement and Insurance Information

I certify that the individual named above is in good physical condition and is capable of participating in the named program. If medical attention beyond first-aid treatment is required, I understand that every attempt will be made to contact me at the emergency number provided. If contact with me is not possible, I give permission for medical attention to be administered. Furthermore, I hereby release, exonerate and discharge the organizers, officers, volunteers, coaches, officials, representatives, employees, and agents from any and all actions and for any injuries or damages incurred while participating in, or travelling to and from, this program.

Parent/Guardian Signature: _____ Date:_____

Participant Signature:_____ Date:_____

Participant's Medical Insurance Company: _____

Total Due $_____ Total Paid $ _____ Check # _____