



FEMALE GOALKEEPER CLINIC – REGION I ODP

INSTRUCTORS:

Tung Nguyen

and other
Region 1 GK Coaches

March 22, 2009

WHEN: 5 – 6:30 (ages 9-12)

6:30-8:00 (ages 13-18)

WHERE: Schulte Park

Electric Ave. Dover, DE 19904

OPEN TO ALL FEMALE GOALKEEPERS

\$40 fee – make checks payable to DYSA

Mail to: Tung Nguyen

11400 Moore Drive

Manassas, Virginia 20111

Questions Email: keepercoach2002@yahoo.com

PLAYER INFORMATION AND MEDICAL RELEASE FORM

Player's Name: _____ Date of Birth: _____ Email: _____
Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY INFORMATION

Father's Name: _____ Home Phone: _____ Cell Phone: _____
Mother's Name: _____ Home Phone: _____ Cell Phone: _____

In an emergency, when parents cannot be reached, please contact:

Name: _____ Home Phone: _____ Cell Phone: _____
Name: _____ Home Phone: _____ Cell Phone: _____

Allergies: _____

Other Medical Conditions: _____

Player's Physician: _____ Home Phone: _____ Work Phone: _____

Medical and/or Hospital Insurance Company: _____ Phone: _____

Policy Holder: _____ Policy #: _____ Group #: _____

PLEASE COPY BOTH SIDES OF YOUR MEDICAL INSURANCE CARD & ATTACH TO THIS FORM

PARENT'S APPROVAL AND MEDICAL RELEASE

Recognizing The possibility of physical injury associated with soccer and in consideration for the USSF/USYS Youth Soccer and its affiliates accepting the registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify the USSF/USYS, its affiliated organizations and sponsors, their employees and associated personnel, including the owner of fields and facilities utilized for the Programs against any claim by or on behalf of the registrant as a result of the registrant's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize.

My son/daughter has received a physical examination by a physician and has been found physically capable of participating in the Programs. I hereby give my consent to have an athletic trainer and/or doctor of medicine or dentistry provide my son/daughter with medical assistance and/or treatment and agree to be responsible financially for the reasonable cost of each assistance and/or treatment.

Signature of Parent/Guardian

Date