



\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Work/Cell Phone

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Date of Birth

Boy \_\_\_\_\_ Girl \_\_\_\_\_

\_\_\_\_\_  
Club Affiliation

**Fee includes 6-1hr sessions with licensed professional  
coaches from the San Diego Soccer Club**

\_\_\_\_\_  
Parent/Guardian Name

**Fee: \$50**

Dates: June 8th, 15th, 22nd

July 6th, 13th, 20th

**6:00 - 7:00 p.m.**

**Location: RB Community Park**

I hereby authorize the staff of the San Diego Soccer Club to act on my behalf and to the best of their ability in any emergency requiring medical attention. I also hereby release, discharge, and/or otherwise indemnify San Diego Soccer Club, its affiliated organizations and sponsors, their employees and associated personnel, including the owners 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.

Signature of Parent/Guardian \_\_\_\_\_

\_\_\_\_\_  
Family Physician

\_\_\_\_\_  
Physician's Phone Number

\_\_\_\_\_  
Health Care Carrier

\_\_\_\_\_  
Policy Number

Known Medical Problems/Allergies \_\_\_\_\_

I also understand that the club retains the right to use for public and/or advertising purposes photos taken during the clinics.

Initials of Parent/Guardian \_\_\_\_\_

Please make checks payable to:

**San Diego Soccer Club**

And mail to:

San Diego Soccer Club  
c/o Jim Flowers - Program Administrator  
12463 Rancho Bernardo Road #515  
San Diego, CA 92128