CLAWSON TOP SOCCER REGISTRATION FORM

Name _____ Date of Birth_____

Address_____City_____ State_____ Zip_____

Parent's Name (Legal Guardian)_____

Address_____City_____ State_____ Zip_____

Phone (____) _____-_____

Emergency Phone #_____ Contacts Name_____

Insurance Company_____ Policy #_____

Health Information (Circle those appropriate)

Down Syndrome	Atlanto-axial Instability	Diabetes
Heart Problems	Seizure Disorder	Visually Impaired
Hearing Impaired	Fainting Spells	Non-verbal, signs
Hepatitis	Bleeding Problems	Mobility Impaired
Asthma	Emotional Problems	Learning Disabilities
Allergies	High Blood Pressure	Low Blood Pressure

Others: Please List_____

List Aids Used (such as a wheelchair, hearing aid, glasses, etc.)

_____

_____

List Allergies

_____

_____

Medications:

Name Dosage Side Affects

_____

_____

_____

List any other information that the coaching staff needs to know about your child

_____

_____

_____

Parent/Guardian Signature_____ Date_____