



Select Try-Outs

Registration Form | 2018-19

OFFICE USE:

#

First Name: _____ DOB: _____

Parent's First Name: _____ Parent's Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell Phone: _____

Email 1: _____ Email 2: _____

PLEASE BRING THIS FORM WITH YOU TO TRY-OUTS WITH A \$20.00 TRY-OUT FEE!

OR PRE-REGISTRATIONS — Send to Kristen Wallace: Fax 502.899.3566, Email kwallace@mockingbirdsoccer.net

If not a previous KFJ player, please list most recent club affiliation: _____

Please circle your preferred playing position: F MF D GK

Please Circle a Try-out Team:	U8(2011)	U9(2010)	U10(2009)
	U11(2008)	U12(2007)	U13(2006)
	U14(2005)	U15(2004)	U16(2003)
	U17(2002)	U18(2001)	U19(2000)

Please Circle Gender: Boy Girl

Payment Options - Please Check the Option by Which You are Paying:

Cash Check Visa Mastercard Discover AMEX

Card Number: _____ Expiration Date: ____/____

Name On the Card: _____

Signature: _____

By signing above you are authorizing Mockingbird Valley Soccer Club to charge your credit card for the amount listed above. All credit card information is maintained in strict confidence and is used only for the payment upon your signature and approval.

Consent for Medical Treatment and Liability Waiver

I, the parent/guardian of the registrant, a minor, agree that I recognize the possibility of physical injury associated with soccer and in consideration of Mockingbird Valley Soccer Club/Kentucky Fire Juniors (MVSC/KFJ) accepting the registrant for its Select Tryouts, I hereby release, discharge and /or otherwise indemnify MVSC/KFJ, and its employees and associated personnel, including owners of fields and facilities used for the Select Tryouts, against any claim by or on the behalf of the registrant as a result of the registrant's participation in the Select Tryouts.

As a parent or legal guardian of the above-named player, I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve life, limb, or well-being of my dependent.

Signature of Parents: _____ Date: _____