For Office Use Only

Age Group: _________Gender: ________

Amt Paid: ________Cash/Check:______

Credit Card Rct #: ___________________

Sibling: Yes __________ No __________

Payment for: SEASON ONLY or YEAR

Birth Certificate on file? _____________

Date Received: _____________________

Carolina Elite Soccer Academy

TOP Soccer Registration Form

Mail to: Registrar c/o CESA
18 Boland Court, Greenville, SC 29615
Office: 864.329.1113 Fax: 864.329.1103
www.CarolinaEliteSC.com

Fees and Placement Information: there is no cost to participate in TOP Soccer

PLEASE COMPLETE ALL PAGES

PLEASE PRINT OR TYPE

Player's Name:____

(First and Last - As it is listed on the birth certificate)

Birth Date:______________________________(*Month/ Day/ Year)*

Gender (circle): M or F

Nickname:______________________________**School**:______________________________

Email Address: ____

Home Phone #: ____________________**Cell #:**______________________________

Home Address:____

City: ______________________________ **State:** _____ **Zip:** __________________

Scheduling Information:

TOP Soccer schedules are posted on the CESA web site. We attempt to have 6 sessions in the fall and 6 in the spring usually on Sunday afternoons lasting for 90 minutes.

Releases

I, the parent/guardian of the registrant, a minor, agree that the registrant and I abide by the rules of Carolina Elite Soccer Academy, SC Youth Soccer, the US Youth Soccer, US Club Soccer and their affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration for Carolina Elite Soccer Academy, SC Youth Soccer, US Youth Soccer, and US Club Soccer accepting the registrant for its soccer programs and activities (the "Program"), I hereby release, discharge and/or otherwise indemnify Carolina Elite Soccer Academy, SC Youth Soccer, US Youth Soccer, US Club Soccer, their affiliated organizations and sponsors, their employees, medical personnel, and associated personnel, including owners of fields, facilities utilized for Programs, against any claims by or on behalf of the registrant's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize.

Therefore, I hereby grant my child's coach or team manager permission to act as my agent in the area of obtaining medical treatment by a doctor of medicine or dentistry. I also assume financial responsibility for any and all medical or dental treatment for my child. The above information pertaining to my child is true and correct to the best of my knowledge. My child has received an examination by a physician and has been found physically capable of participating in all of the CESA Soccer Programs.

I authorize Carolina Elite Soccer Academy to provide the information contained on this form to its sponsors and any other entities at its discretion.

I HAVE READ AND AGREE TO THE TERMS LISTED UNDER CODE OF CONDUCT AND RELEASE STATEMENTS.

Parent Signature:______________________________________Date:______________________________

****I give my permission to have my child photographed during games or practice for use on the website, newspaper, media or for sponsorship information. At no point will CESA give out player's names with pictures.**

If you DO NOT want your child photographed initial here: ______________

Bon Secours St. Francis Health System, Inc.
St. Francis Sports Medicine

Player Name ____DOB ______________________

Phone # ________________Cell #___________________

Grade __________

Address ____

Father Name ___________________________________Cell # ____________________________

Home # ___________________________ E-mail _____________________________________

Mother Name____________________________________ Cell # ____________________________

Home # ___________________________ E-mail ____________________________________

Insurance Carrier ____

Emergency Contact ____

Phone #'s ____

Yes/ No Does your child have any of the following? (Check appropriate box and list details)

Medical Alert Allergies ____
Allergic to any medication(s) ____
Asthma ______________Do you have an Inhaler? _____________________________
Heart Condition ____
Vision loss ____
Epilepsy ____
Diabetes ____
Kidney condition ____
Hearing loss ____
Severe headaches ____
Other ____

____

Additional medical information:
Previous injuries/surgeries (month/year)? ____
____
Date of last tetanus booster: _______________________________
Is your child on any medication that is taken on a regular basis? (List)_____________________
____
Does your family have a primary care physician? (Name/ phone#)
____
Does your family have an orthopedic MD? ____
My child may take any over-the-counter medication such as Tylenol®/Advil® yes no
Specific ____

Parent/Guardian Signature _________________________________ Date ______________________

BON SECOURS ST. FRANCIS HEALTH SYSTEM, INC.
CERTIFIED ATHLETIC TRAINING SERVICES
CONSENT AND AUTHORIZATION

I, ________________, parent/legal guardian of ______________________, an athlete at Carolina Elite Soccer Academy (CESA), authorize Bon Secours St. Francis Health System, Inc., SFHS staff to provide my child any healthcare services offered by SFHS Certified Athletic Training Services and to make appropriate referrals for my child to receive any additional health services that my child's condition may indicate. To protect and improve the health of athletes, SFHS will provide an athletic trainer to provide on-site treatment and consultation to athletes at CESA. These services will be overseen by a physician serving as Medical Director for Certified Athletic Training Services.

In addition, in the event my child needs urgent or emergency treatment off-site, I authorize staff at SFHS Certified Athletic Training Services to arrange for such care, including appropriate transportation. I understand that SFHS Certified Athletic Training Services staff will contact me as soon as possible in the event my child has an urgent or emergency condition.

I agree to complete all health history, family history, and other informational requests necessary for my child's participation in the Certified Athletic Training Services program. I understand that I may contact the Athletic trainer assigned to CESA or the Medical Director for Certified Athletic Training Services to discuss my child's care or to discuss any questions I may have about the program. I consent to the release by SFHS staff of information about my child's medical condition obtained through Certified Athletic Training Services to coaches and other employees or agents of CESA.

I understand that I will not be charged for services rendered on-site by the Athletic trainer assigned to CESA, but that I or my insurance carrier will be charged for services rendered by other healthcare providers.

I consent for information in my child's medical record to be released for the purpose of filing health insurance claims with third-party payers. I hereby authorize SFHS to submit claims for services rendered to my child and assign to SFHS my rights to any reimbursement for such services.

In consideration for the services provided to my child by SFHS Certified Athletic Training Services, I hereby release Bon Secours St. Francis Health System, its trustees, officers, employees, and agents from and against any claim, liability, cause of action or other expense arising out of the services provided by SFHS Certified Athletic Training Services.

I have read and understand the above information and consent to my child's participation in SFHS Certified Athletic Training Services.

______________________________	______________________________
Name of Parent (of minor patient), Closest Relative, or Other Legal Representative (please print)	Name of Athlete (please print)
______________________________	______________________________
Signature of Parent (of minor patient), Closest Relative, or Other Legal Representative	Relationship to Athlete (please print)
______________________________	______________________________
Witness	Date

Emergency Contact Names Telephone Numbers

______________________________ Day _____________________ Night ___________________

______________________________ Day _____________________ Night ___________________