

**PLAYER CAMP REGISTRATION**

**Mail to:**

Premier Athletics Club  
ATTN: Summer Camps  
4201 Wilson Blvd, #110553  
Arlington, VA 22203-1859

Male  Female  Member of PAC? YES NO

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

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

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Cell Phone(s): \_\_\_\_\_

Work Phone(s): \_\_\_\_\_

E-mail: \_\_\_\_\_

Age: \_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

School Attending: \_\_\_\_\_

Team Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy number: \_\_\_\_\_

Allergies or Medications: \_\_\_\_\_

**Premier Athletics Club** requires the following: We, the undersigned parents and/or legal guardians of a training participant under the age of 21 years, do hereby agree that he or she may participate in soccer training sessions given by Sully Hamid and the staff of P.A.C. In consideration that he or she has been accepted by for instruction, we do further agree for and on behalf of him or her, and for ourselves individually and severally, that we will assume all risks in conjunction with such course of instruction and that we will hold P.A.C. and the coaching staff harmless against all claims for damage to person or property occasioned by such training, with the exception that P.A.C. and the coaching staff are not hereby released of liability for any negligent acts.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Registration Fee: \$300 for non-members / \$250 for PAC members

## **MEDICAL RELEASE FORM**

As the parent/legal guardian of \_\_\_\_\_,  
born \_\_\_\_\_ I hereby give my consent and permission for  
the player named below to be medically and/or surgically treated for injuries  
and/or illness of any kind or seriousness under the direction of the staff of PAC,  
until such time as I can be contacted. Further, I give my consent and permission  
to the physician and/or hospital and/or other health care provider selected to  
provide medical or surgical treatment, including, without limitation, dental care,  
hospitalization, injection, anesthesia, invasive surgery or any other form or kind  
of medical or surgical care (emergency or otherwise) for the player.  
Known allergies of this player, including any allergies to medicine

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family Physician: \_\_\_\_\_  
Phone: (     ) \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip Code: \_\_\_\_\_  
Phone: (H) \_\_\_\_\_  
Phone: (W) \_\_\_\_\_  
Phone: (Cell) \_\_\_\_\_

Person to notify if parent/guardian is unavailable:

\_\_\_\_\_

Phone: \_\_\_\_\_

Insurance Carrier:

\_\_\_\_\_  
Group Number: \_\_\_\_\_

Signature of Parent/Guardian

\_\_\_\_\_ Date: \_\_\_\_\_