Name of participant: _____Surname: _____D.O.B: _____/_____/_____

Parents/Guardians Name: _____ Emergency Contact No. _____

Mobile: _____ Email address: _____

Location: RYDALMERE FC SOCIAL – Park Rd **(Please Circle Preferred Day)**

Class Day: WEDNESDAY **Age Group: 3 – 5 years old** **Class time: 10:00am - 11:00am**

Parents/Guardians Name: _____ Emergency Contact No. _____

Name and Address of Family Doctor (if applicable): _____

Medicare No: _____Private Health Care Details (if applicable): _____

Health Care Card No: _____ Ambulance Cover: Yes No Number: _____

Does your child suffer from any of the following?

◯ Epilepsy ◯ Heart Conditions ◯ Asthma ◯ Diabetes ◯ Blackouts ◯ Migraines ◯ Other

_____

Allergies to: Penicillin _____Other Medication _____

What special care is recommended: _____

Is your child on any form of ongoing medication, if so please specify:

FEES: $220 including G.S.T for a 10 week Program. 1 hour class. We also provide a Sibling Discount of $10.
Payment by EFT: will need to be made prior to commencement of Term.

Bank:	-	Commonwealth
Account Name:	-	Soccer 4 Tots
BSB:	-	062-601
Account Number	-	1043 2390

When making PAYMENT ELECTRONICALLY please use PLAYERS SURNAME AND FIRST INITIAL as the PAYMENT REFERENCE.

Payment in Cash: will need to be made on the first day of your child participating. Please ensure that it is in an envelope with your child's name on it and the correct amount.

WAIVER
The undersigned in their capacity as parent/guardian of _____

acknowledges that they have read and understood the Terms & Conditions stated by Soccer 4 Tots and that this project is organized and managed by the Soccer 4 Tots Staff. The participant and hereby waives any claim against Soccer 4 Tots and their affiliated companies and project he/she is being enrolled to. Our Terms & Conditions can be found on our website.

CONSENT TO MEDICAL ATTENTION
Where the Coach or Club Management is unable to contact me, or it is impracticable to contact me, I hereby give permission to the Coach or Club Management to seek treatment for my child at a hospital, or to call a Doctor and/or ambulance and/or dentist during an emergency and agree to pay all relevant costs involved.

Name of Parent/Guardian _____

Signature_____Date _____