



Name of participant: _____ Surname: _____ Date Of Birth: ____/____/____

Parents/Guardians Name: _____ Mobile: _____

Email address: _____ Emergency Contact No. _____

Locations: [WINMALEE - Tennis Centre - Hawkesbury Rd](#)

Class Day: **SATURDAY (Winmalee)** (please circle preferred class time below)

Age Group: 3 – 5 years old **WINMALEE Class starting time: 9:00am – 10:00am**

Age Group: 3 – 5 years old **WINMALEE Class starting time: 10.15am – 11:15am**

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 symptoms?

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 state?

FEES: \$200 GST included - 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: - One Goal Futbol
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 _____