



GOALKEEPER TRAINING

BLAINE SOCCER CLUB ★ PO BOX 490043 ★ BLAINE, MN 55449

★ 763 792 7369 www.blainesoccer.org

IMPROVE YOUR GOALKEEPING SKILLS AT BLAINE SOCCER CLUBS FALL GOALKEEPER TRAINING

Dates: Sept 10, 17, 24 and Oct 1 (Friday nights) @ the Blaine Soccer Complex (F1North)
U9-U14 BSC Keepers: 6:00pm - 7:00pm

Cost for the 4 session program is \$30

Mail-In Registration to: GOALKEEPING, BLAINE SOCCER CLUB, P.O. Box 490043, Blaine, MN 55449.

**REGISTRATION IS ON A FIRST COME FIRST SERVED BASIS (Limited group size).
PROGRAM OPEN ONLY TO REGISTERED BLAINE SOCCER CLUB FALL TRAVEL PLAYERS**

Name: _____ AGE: _____ Male Female
First Last

Address: _____
Street City Zip code

Telephone Number: _____ E Mail (Please Print): _____

BSC Fall Team (Age group, Coaches Name) _____

Father's Name: _____ Cell or Work Number _____

Mother's Name: _____ Cell or Work Number _____

Any Medical Problems or Restrictions the Player Has: _____

Alternate Contact: _____ Alternate Telephone Number: _____

Physician/HMO/Clinic Name: _____ Phone: _____

Dentist Name: _____ Phone: _____

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

Signature of Parent or Guardian Date

Consent for Medical Treatment As the parent/legal guardian of a registrant in the Blaine Soccer club programs; I hereby give my consent for EMERGENCY medical care 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 Parent or Guardian Date

2010 Fall Goalkeeping