

# LONDON KIWANIS TAKACS SOCCER PROGRAM

Open to all London and surrounding area boys and girls in grades 1 through 8 not on a club or school team.  
Matches will be played weekly on Sunday afternoons at St Patrick's School from the **September 11<sup>th</sup> to October 30<sup>st</sup>**.  
8 Game season this fall. Practices are held twice weekly at Coaches discretion for days and times.

This Registration form must be received, along with the league fee **by AUGUST 7<sup>th</sup>** to insure your child's participation. Cost is \$30.00 for ONE child, \$15.00 for each additional child in the same immediate home.

Please make checks payable to:  
**LONDON KIWANIS CLUB**

MAIL Registrations to: **Jeff Stiffler**  
**1406 Itawamba Trl**  
**London, Oh 43140**  
740-852-5540

-----<Cut here and send bottom portion with your league fee>-----

Child's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_

Previous Years of Soccer Experience: \_\_\_\_\_ In the Kiwanis League: \_\_\_\_\_

Last Team played with: \_\_\_\_\_ Coach: \_\_\_\_\_

Email Address: \_\_\_\_\_ Text #: \_\_\_\_\_

## Medical Information and Release Form

**Release:** My child has my express permission to participate in the London Soccer Program. I will not hold the Board, Officers, Sponsoring Organizations, Coaches, Referees or Facility locations responsible for any injuries in connection with the soccer program.

**Emergency Medical Authorization:** In the event that reasonable attempts to contact us have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by our Physician, or Dentist, or in the event the designated Physician or Dentist is not available, by another licensed Physician or Dentist, and the transfer of the child to the preferred hospital or any hospital reasonably accessible. This authorization does not cover major surgery, unless the medical opinions of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery. Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted are listed below:

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1<sup>st</sup> CONTACT: (Parent or Guardian)

NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_

2<sup>nd</sup> CONTACT:

NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_

Preferred Physician and Phone: \_\_\_\_\_

Preferred Dentist and Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Yes! I (we) would like to help with the following: \_\_\_\_\_ Coaching \_\_\_\_\_ Refereeing

Name(s): \_\_\_\_\_

Contact: Jeff Stiffler 740-852-5540 website: [www.londonsoccer.org](http://www.londonsoccer.org) Email: [londonsoccer@aol.com](mailto:londonsoccer@aol.com)

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