



Spokane Shadow Practice Agreement & Waiver

**Completed form due to the team coach, Shadow Administrator
(admin@spokaneshadow.org) and Shadow Bookkeeper
(shadowssoccer@spokaneshadow.org) prior to the player's first practice.**

Player Name: _____ Birth Date _____ Age: _____

Parent's Names: _____ Grade: _____

E-mail Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Age Group: _____ Practice Dates: _____

Fee: _____

MEDICAL CONSENT AND RELEASE OF LIABILITY

I, the undersigned parent/guardian of a minor, do hereby authorize the Shadow Soccer Club as Agents for the undersigned to consent to Medical, Surgical or Dental Examination or Treatments. In addition, I hereby release and discharge the Inland Empire Youth Soccer Association, the City of Spokane, and the Shadow Soccer Club, its officers, board, agents and employees for any injury, loss or liability, which results or is alleged to have resulted from participation in the Shadow Youth Soccer Club practices or games. I have read the above and fully understand the Medical Consent and Release of Liability.

Player Printed Name: _____

Player Signature: _____

Parent Signature: _____ Date: _____

Emergency Contact: _____ Phone: _____
(other than Parent / Guardian)