

PHOTOS

Please attach two recent photos.



2006 REGISTRATION FORM

2006 Registration Fee: \$50 per player or \$100 per family. Please make check payable to Chicago Celtic Youth GFC.

Player's Signature: _____

DIRECTIONS: 1) Please PRINT HARDCOPY form. 2) Complete in full. 3) Please staple or paperclip two recent photos of player in the box above. 4) Include a copy of player's birth certificate. 5) Include a copy of medical insurance card. 6) Parent/guardian SIGN at places indicated. 7) Players should sign below picture (above) in front of Registrar.

PLAYER'S FIRST NAME: _____ LAST NAME: _____ INIT. _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE _____

TELEPHONE: (_____) _____ E-MAIL ADDRESS _____

BIRTHDATE MM/DD/YY: ____/____/____ MALE/FEMALE (M/F): _____ COUNTRY OF BIRTH: _____

We will be compiling a Club Directory. The directory will be distributed to families listed. Would you like your contact information included in the directory? Yes No

FATHER'S NAME: _____ OCCUPATION _____

MOTHER'S NAME: _____ OCCUPATION _____

CELL PHONE/WORK PHONE: _____

LIST ANY MEDICAL CONDITION OR PROHIBITION REGISTRANT HAS: _____

PERSON TO NOTIFY OTHER THAN PARENT IN EMERGENCY: _____ TELEPHONE: _____

DOCTOR TO NOTIFY IN EMERGENCY: _____ TELEPHONE: _____

CURRENT SCHOOL: _____ GRADE: _____ NUMBER OF PRIOR SEASONS PLAYED: _____

WE NEED PARENT VOLUNTEERS! PLEASE INDICATE YOUR 1ST AND 2ND CHOICES FOR THE ACTIVITIES BELOW:

Coach ___ Asst. Coach ___ Div. Coordinator ___ Team Parent ___ Field Prep. ___ Clerical ___ Fundraising ___ Other _____

IMPORTANT I, the parent/guardian of the registrant, a minor, agree that I and the registrant will abide by the rules of the GAA, its affiliated organizations, and sponsors. Recognizing the possibility of physical injury associated with Gaelic Football and in consideration for the GAA accepting the registrant for its Gaelic Football programs and activities (the "Programs"), I hereby release, discharge, and/or otherwise indemnify the GAA, its affiliated organizations and sponsors, their employees and associated personnel, including the owners of fields and facilities utilized for the Programs, against any claims 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.

Name of Parent/Legal Guardian (Please Print) _____

Signature X _____ Date _____

CONSENT FOR MEDICAL TREATMENT (MINOR) - As the parent or legal guardian of the above-named registrant, I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of my dependent.

Signature of Parent or Guardian X _____ Date _____

Address _____ City _____ State _____ Zip _____