

FC Brenham (FCB) Adult Application

Persons over 17 who wish to participate as player, coach or administrator must be certified "Kidsafe" by South Texas Youth Soccer Association (STYSA) after a background check and **before** any contact with players or accessing player's personal information. After completing and signing the application it must be sent by mail, FAX, Email attachment or hand delivery to Ken Morris, FCB Registrar, 1009 W Lubbock, Brenham, TX 77833, Cell: 979-451-1111, FAX: 979-353-0843, Email: ken@lomor.org You will be notified when the application has been approved.

Name _____
Legal First Legal Middle Legal Last Suffix

Date of Birth ____/____/____ Male Female Phone (____) _____
Mo Day Year

Address _____

City _____, Texas ZIP _____

Email Address _____

Position Player Coach Trainer Team Assistant Team Manager Referee
Of Interest:
Board Member Commissioner Other _____

Years Coaching Experience _____ License Issued By _____

Coach License Level _____ Coaching License No _____

Coach License Date ____/____/____ Coach License Expire Date ____/____/____
Mo Day Year Mo Day Year

Texas Drivers License No. _____ DL Expiration Date ____/____/____
Mo Day Year

AGREEMENT AND RELEASE – I agree to abide by the rules of the FCB, its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration for the USYSA, accepting me in its soccer programs and activities (the "Programs"). I hereby release, discharge and/or otherwise indemnify the FCB, its affiliated organizations and sponsors, their employees and associated personnel, including the owners of fields and facilities utilized for the Programs, against any claim by me as a result of the my participation in the Programs and/or being transported to or from the same. **I authorize a background check for the purpose of determining "Kidsafe" eligibility.**

CONSENT FOR MEDICAL TREATMENT – 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 my life, limb or well-being. Known medical problems are listed on the back of this application.

To the best of my knowledge this application is true and complete.

Signature _____ Date ____/____/____
Month Day Year

Received on ____/____/____ By _____ FCB Entered on ____/____/____ By _____
Mo Day Year Initials Mo Day Year Initials