



2009-2010 Developmental & Recreational Registration

Priority Registration Deadline 11/1/2009

RETURN FORM AND FEES TO: BCF Soccer Club • 2769 Iris Ave, Suite 115 • Boulder, CO 80304 • Fax (720) 406-1566

Phone: (303) 443-8877 www.bcfrc.com

Check One Only:

- U5-U7 (K-1st Grade)** Recreational / **\$55** Spring before 11/1, **\$65** after.
- U8 (2nd Grade)** Recreational / **\$80** Spring before 11/1, **\$90** after.
- U9 & U10 (3rd-4th Grade)** Developmental Academy / **\$200** spring season. *(Includes BCF Trainers 2x/week)*
- U9-U14 (3rd-8th Grade)** Recreational / **\$155** spring season.

For Office Use Only:

Uniform not included (\$49.95 + tax), available at Rocky Mountain Soccer • 2767 Iris Ave. • Boulder, CO 80304 • Phone (303) 938-9166

PLAYER INFORMATION – Please write legibly.

First Name: _____ Last Name: _____ Date: ____/____/____

Address: _____ Male _____ Female _____

City: _____ State _____ Zip: _____ Home Phone: (____) _____

Date of Birth: ____/____/____ Grade (Fall '09): _____ Primary email: _____

Referred by (*New players only*): _____ Team last played for: _____

PARENT INFORMATION

Mother's Name: _____ Email: _____ Cell Phone: (____) _____

Father's Name: _____ Email: _____ Cell Phone: (____) _____

Player lives with (circle one): Mom Dad Both Alternates

CONSENT FOR EMERGENCY MEDICAL TREATMENT AND PERMISSION TO PLAY

I, undersigned, give consent for my child to participate in the activities of the Boulder County Force Soccer Club. I further agree to hold harmless, indemnify, release, and discharge Boulder County Force Soccer Club, its directors, officers, agents and employees, for all claims or action due to personal property or personal injury which may result from my child's participation. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected to hospitalize or seek proper treatment for my child.

SIGNATURE OF PARENT/GUARDIAN: _____ Date: _____

Physician Name: _____ Physician Phone #: _____

TEAM REQUEST- There is no guarantee regarding team placement.

Coach/Team: _____ Friend: _____

Note that team requests must be approved by the Team Coach and are FINALIZED by BCF Staff.

PAYMENT

Payment by: check credit card (VISA & MasterCard Only): Amount Paid: \$ _____

Credit Card # _____ 3 Digit Code: _____ Card Exp. Date: _____

Name on Credit Card: _____

Billing Address of Credit Card: _____

I AM APPLYING FOR A SCHOLARSHIP, AVAILABLE ON A NEED BASIS. SCHOLARSHIP FORMS AVAILABLE AT BCFORCE.COM

I have submitted the supporting documents required for review of my scholarship application.

REFUND POLICY:

Registration fees are nonrefundable. However, in the event a physician-documented illness or injury prevents a player from participating or a player's primary residence becomes more than 30 miles away from the BCF office, a prorated refund may be available. Refunds are subject to BCF Board approval. A \$150 administrative fee will be deducted from refunds. In addition, the number of games and tournaments played will be prorated and deducted from refunds.