# FBC UNITED

…invites you to join our fourth annual five-week soccer program on Wednesday evenings and Saturday mornings, from July 3 to July 27, at Fellowship Baptist Church. This program will provide foot skill clinics and competitive games for boys and girls ages 5 through 14. A short Bible lesson will be included each Wednesday.

**Cost:** $20 per child, which includes all fees and a jersey

**Dates:** July 3, 6, 10, 13, 17, 20, 24, and 27. Wednesday evening sessions run from 6:45 to 8:00 pm; Saturday morning sessions are held from 9:00 to 10:15 am.

**Place:** Fellowship Baptist Church, 605 Welsh Road, Watertown, WI 53098 (info@fbcwttn.org)

**Register** on the church's website: www.fbcwttn.org or mail forms into the church office at the address given above. Space is limited so register early!

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**FBC United Registration Form (2024)**

Name_____ Age_____ M or F

Address_____ City_____

Phone_____ Email_____

Shirt Size: YS YM YL AS AM AL AXL

List any special needs or medical conditions this participant has_____

I understand the inherent risk of injury in participation in this soccer program and verify that my child is medically fit to participate. I give my permission to the supervisors of this program to take the proper steps in case my child is in need of emergency medical attention. I also release the sponsoring groups and their agents from any and all claims arising from this child's participation in this activity.

Signature of Parent/Guardian _____ Date _____

**(See other side for concussion agreement)**

# Fellowship Baptist Church
# Parent & Athlete Concussion Agreement

**As a Parent and as an Athlete it is important to recognize the signs, symptoms, and behaviors of concussions.** By signing this form, you are stating that you understand the importance of recognizing and responding to the signs, symptoms, and behaviors of a concussion or head injury.

## Parent Agreement:

I/we have **read** the Parent Concussion and Head Injury Information and **understand** what a concussion is and how it may be caused. I/we also understand the common signs, symptoms, and behaviors. I/we agree that my child must be removed from practice/play if a concussion is suspected.

I/we understand that it is my responsibility to seek medical treatment if a suspected concussion is reported to me.

I/we understand that my child cannot return to practice/play until providing written clearance from an appropriate health care provider to his/her coach.

I/we understand the possible consequences of my child returning to practice/play too soon.

## Athlete Agreement:

I/we have **read** the Athlete Concussion and Head Injury Information and **understand** what a concussion is and how it may be caused.

I/we understand the importance of reporting a suspected concussion to my coaches and my parents/guardian.

I/we understand that athlete must be removed from practice/play if a concussion is suspected. I/we understand that the athlete must provide written clearance from an appropriate health care provider to my coach before returning to practice/play.

I/we understand the possible consequence of returning to practice/play too soon and that athlete's brain needs time to heal.

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**Parent/Athlete Concussion Agreement**

My child & I have read the above statements and sign acknowledging that if a concussion is suspected that the athlete will not play until clearance is given from the health care provider.

Parent/

Guardian Signature_____ Date_____

Athlete Signature_____ Date_____