



CEREBRAL PALSY AMBULANT FOOTBALL LEAGUE

PLAYER REGISTRATION FORM £5-00 payable to CP Sport

Full Name of Player

Address

..... Post Code

Telephone No Date of Birth

Mobile:.....e mail:.....

School team/club team currently playing for

Address.....

..... Telephone No

Favoured Position Alternative position

Disability Category/Group:.....

Signed (Player) Date.....

Player/Parent/Carer, please complete the following section

Has the player, at any time, received an Anti-Tetanus injection?Yes/No

If yes please give appropriate date

Is the player allergic to any medical treatmentYes/No

If yes, please give details

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Please state any other medical details you consider to be relevant

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I am pleased to allow the above mentioned player to play in the Cerebral Palsy Football League, as allowed within the rule structure of the Football Association and in the event of an injury I give my consent for any immediate treatment, deemed necessary, by a qualified physiotherapist or medical practitioner.

Signature of Parent/GuardianDate.....