

Please complete form and mail or fax to:  
480 Briarwyck Drive  
St. Louis, MO 63011  
Phone: 314-374-6104  
Fax: 314-787-9205



## 2007 YOUTH REGISTRATION FORM

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

DAY PHONE: \_\_\_\_\_ EVENING PHONE: \_\_\_\_\_

PARENT/GUARDIAN: \_\_\_\_\_ EMAIL: \_\_\_\_\_

SCHOOL/TEAM: \_\_\_\_\_ POSITION(S): \_\_\_\_\_

AGE: \_\_\_\_\_ GRADE (FALL 2007): \_\_\_\_\_

COACH NAME: \_\_\_\_\_

### Choose Your Training Package

#### Youth Group Training

*1-Hour Sessions*

Position:    QB    WR    RB    OL    LB    DL    DB

Choose Package:    1 Session \$40.00    5 Session Pack \$145.00    10 Session Pack \$250.00

#### Youth 1-on-1 Training

*1-Hour Sessions*

Position:    QB    WR    RB    OL    LB    DL    DB

Choose Package:    1 Session \$55.00    5 Session Pack \$245.00    10 Session Pack \$450.00

**Package Total: \$** \_\_\_\_\_

**Amount Paid: \$** \_\_\_\_\_

***EFA STAFF ONLY***

**Payment Type:** Cash   Check   Charge

**Date:** \_\_\_\_\_   **CK#:** \_\_\_\_\_

**Received By:** \_\_\_\_\_

**ELITE FOOTBALL ACADEMY  
MEDICAL WAIVER  
EMERGENCY CONTACT INFORMATION**

My signature on this form indicates I have read, understand, and abide by the following information. My child has my permission to participate in Elite Football Academy training sessions. I certify that my child has been examined by a licensed physician within the last 12 months, and is able to participate in all football related physical activities. I understand that my child may come in contact with other people and objects, and I hereby waive all rights to future claims related to such contact or injuries sustained as a result of such contact. I agree to assume any and all risks associated with my son's participation in Training Sessions and release Elite Football Academy, its Owner, Staff, Participating Facilities, Host Schools and their respective School Districts from any and all liability related to injury or illness my son may sustain during training.

I authorize Elite Football Academy, in the event of a medical emergency to transport and/or seek the necessary medical treatment for my child.

**Student Athlete Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Insurance Carrier:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**My child is allergic to the following medications:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Alternate #:** \_\_\_\_\_