



**CEREBRAL PALSY AMBULANT FOOTBALL LEAGUE  
PLAYER REGISTRATION FORM**

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 treatment .....Yes/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/Guardian .....Date.....