PRIDE SOCCER CLUB

"Doing what's right for kids"

www.pridesoccer.com 2660 Vickers Dr. Colorado Springs, CO 80918 719-597-6700 Fax: 719-597-4040

Little Cubs Soccer Program	**Pride Soccer is proud to offer an indoor soccer program specifically designed for the 3-5 year old rising star! Curriculum will include Individual balls skills such as dribbling and kicking, as well as work on coordination and agility.**
Location:	**Trinity Church of the Nazarene 5055 El Camino Dr From Academy; East on Flintridge. Turn left on El Camino Dr.**
Dates & Times:	**Fridays January 18, 25 February 1, 8 & 15, 2008 9:30-10:30 am**
Age & Level:	**Ages 3-5 Boys and Girls**
Cost:	**$65 (No Refunds after deadline)**
Registration Fee Includes:	• **5 Training Sessions with qualified coaches** • **Age appropriate curriculum** • **T-Shirt**
Uniform:	**Please wear Little Cubs T-Shirt, Shin Guards, Tennis Shoes (no outdoor cleats). Bring Water Bottle. Arrive 15 min early to first session to pick up T-Shirt**
Registration Deadline:	**January 8, 2008 (WALK INS ACCEPTED)**
Payment Information:	**Make checks payable to Pride Soccer and mail to 2660 Vickers Dr. Colorado Springs, CO 80918 or fax to 719.597.4040 with credit card information**

Player Information:

Name: _____ **Age:** _____ **Home Phone:** _____

Address: _____ **Gender** _____ **Birth date**_____/_____/_____ **Zip:** _____

Mothers name_____ **Work** _____ **Cell** _____

Fathers name_____ **Work** _____ **Cell**_____

1st email:

*writing in your email constitutes permission for us to contact you. We do not sell or give out email addresses. All announcements are done through email. Please give us all addresses that will be checked daily

2nd email:

Team Information: **Team Name:** _____ **Age Group: U**_____ **Coach:** _____
(if applicable)

Consent for Emergency Medical Treatment and Permission to Play: The undersigned gives consent for my child to participate in Pride Soccer Camps. I further agree to hold Pride Soccer Camps, coaches and managers harmless for all claims or actions due to personal, property or injury, which may result from my child's participation. In the event I cannot be reached, I hereby give permission to the physician selected to seek treatment for my child.

Parent's Signature: _____ Date

For Office Use Only

Cash _____ Check # _____ Ap # _____ Reg# _____ Int _____ Date _____

O Visa O MasterCard O Discover O Am Express **Name on Card:** _____

Act# _____ **Exp** _____