Boys' 2019 Preseason Soccer Clinic

Fortune Favors the Prepared

Locations/ Time:
The clinic will be held at Old Field Park on Monday, August 19th through Friday, August 23rd. The clinic will run from 9:00 am to11:00 am daily.
The cost of the clinic is $135 per player. ***Please make Checks payable to Elite FC L.LC.***

Description:
This preseason soccer clinic is designed to condition and prepare student athletes for the first week of the fall season. The program is open to all Fairfield High School male soccer players. The clinic will be directed by Justin Ottavio, Head coach at Warde High School and current holder of a National Soccer Coaches' Association of America (NSCAA) High School coaching diploma and Premier diploma. If you have any questions/ concerns please call or text (203) 218-7343

All participants should bring the following gear to each session:

Proper soccer attire	Turfs or cleats	Water
A pair of good running shoes	A soccer ball	Shin Guards

To register for the clinic please complete the form below and mail with payment

to: **Justin Ottavio**
34 Heritage Rd
Trumbull, CT 06611

***** There will be no refunds for cancellations due to inclement weather or field closures.***

***** Registration closes August 1, 2019. *****

Name: ____ Grade: _______________

Address: ____ Phone: _________________

Parent or Guardians Name: _________________________________Cell Phone: _______________

Release and Waiver of liability:
I certify that the applicant is in excellent physical health and is capable of participating in a strenuous physical activity. I further certify that I give permission for him to participate in the soccer clinic being conducted by Elite FC L.L.C. I also agree to hold harmless Elite FC L.L.C and all his employees from any and all injuries sustained by the applicant during his participation in the clinic. In the event of a medical emergency or illness, I hereby authorize Elite FC L.L.C and its employees to provide first aid and/or request emergency medical treatment and transportation to a hospital. I grant permission for the applicant to be given treatment at a local hospital.

Any Allergies: ___________________________ Other: ______________________

Signature of Parent or Legal Guardian: _____________________________________

Print Name: ____ Date: ________________

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