EASTERN DISTRICT DIVISION ONE ASSOCIATION
INDIVIDUAL PLAYER MEMBERSHIP FORM

Proud Member of South Texas Youth Soccer Association
and U.S. Youth Soccer Association

STYSA

US YOUTH SOCCER
The Game for All Kids!

TEAM

Team Name: _____ Team Number: _____

Age Group: U-_____ Coach's Name: _____

PLAYER INFO

Players LastName _____ First _____ Middle Initial ____ ☐ Male ☐ Female

Use Name As It Appears on Birth Certificate Only ---- Do Not Use Nick-Names

Street Address _____ _____

Must enter a physical street address *** P.O. Boxes WILL NOT be accepted

Month / Day / Year Date of Birth

_____

City State ZipCode

Mother's Name: _____ Home Phone: _____

Daytime Phone: _____

Father's Name: _____ Home Phone: _____

Daytime Phone: _____

UNIFORMS INFORMATION

	YOUTH			or	ADULT	
SHIRTS:	XS	S	M	L	XL	
SHORTS:	XS	S	M	L	XL	
SOCKS:	XS	S	M	L	XL	

Circle Youth or Adult, then the appropiate sizes

REQUIRED

I, the parent/guardian of the above listed registrant, a minor, represent and warrant that the above information is true and correct and that I and the registrant will abide by the rules of the USYSA, its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration by the USYSA, accepting the registrant for its soccer programs and activities (the "Programs"). I hereby release, discharge and/or otherwise indemnify the USYSA, its affiliated organizations and sponsors, their employees and associated personnel, including the owners of fields and facilities utilized for the Programs, against any claim by or on behalf of the registrant as a result of the registrant's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize.

Name _____ Signature_X_____ Date _____

Parent/Legal Guardian (please print)

REQUIRED

CONSENT FOR MEDICAL TREATMENT

As the parent/guardian of the above-named player, I request and give consent, in my absence, for emergency medical care prescribed by duly licensed Doctor of Medicine or Doctor of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependant. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named player.

Insurance Carrier_____ Policy Number_____

Person responsible for charges: _____ Home Phone_____

Street Address_____ Bus. Phone_____

City/State/Zip_____

Family Physician_____ Phone #_____

Person to notify if parent/guardian is unavailable_____ Home Phone_____ Bus. Phone_____

Known allergies, including medicine, or other medical problems: _____ Date of last Tetanus Booster _____

Signature of Parent/Guardian _____ Date: _____