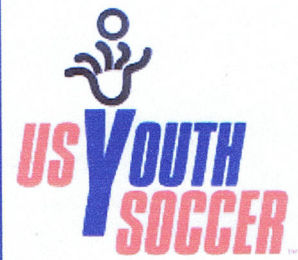




EASTERN DISTRICT DIVISION ONE ASSOCIATION INDIVIDUAL PLAYER MEMBERSHIP FORM

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



The Game for All Kids!

TEAM	Team Name: _____	Team Number: _____
	Age Group: <u>U-</u> _____	Coach's Name: _____

PLAYER INFO	Players LastName _____ First _____ Middle Initial _____	<input type="checkbox"/> Male <input type="checkbox"/> 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	
	City _____	State _____

Mother's Name: _____	Home Phone: _____	UNIFORMS INFORMATION YOUTH or ADULT SHIRTS: XS S M L XL SHORTS: XS S M L XL SOCKS: XS S M L XL
Father's Name: _____	Home Phone: _____	
	Daytime Phone: _____	
	Daytime Phone: _____	

Circle Youth or Adult, then the appropriate sizes

REQUIRED	<p>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.</p>	
	Name _____	Signature_X _____

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: _____