



USYSA Membership Form



ID#	1	CT	SC	175	U-		
	Region	State	District	Club	Age Group	Team	Comp

Official Use Only

Last Name	First Name	Init	Sex

		West Haven
Address	Address Line2	City

CT	06516	(203)			
State	Zip	Area Code	Telephone	Date of Birth	School

Father's Name _____ Bus. Ph. _____

Mother's Name _____ Bus. Ph. _____

List and medical problem player has _____

Person to notify in emergency _____ Telephone _____

Doctor to notify in emergency _____ Telephone _____

Other Children _____ Age _____
 From Family _____ Age _____
 Presently in _____ Age _____
 League _____ Age _____

Team Preference _____

1) I, the parent/guardian of the registrant, a minor, agree 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 for 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.

2) I have reviewed and accept the Concussion and Bullying policies of the West Haven Youth Soccer League

Name _____
 Parent/ Legal Guardian (Please Print)

Signature _____ Date _____

Parental Support
 We ask for active participation of all parents in our program
 Circle area(s) in which you would be willing to help

Coach - Asst Coach

Team Parent

Dance Committee

Publicity

Team Sponsor

CONSENT FOR MEDICAL TREATMENT(MINOR)
 As the parent of legal guardian of the above-named player, I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.

Signature of Parent of Guardian
 X _____
Address _____
City _____ **State** _____ **Zip** _____
Phone: Home _____ **Bus** _____

Official Use Only	Birth Date Verified
Registration Fees: Recd by: _____ Date: _____	
Player Fee..... \$ _____	
Other Fee..... \$ _____	
Total \$ _____	
Cash \$ _____	Check No. _____ \$ _____
Registration Fee Not Refundable	