



This form should be submitted to your home team's club.

### YOUTH PLAYER REGISTRATION FORM

This form must be retained by the club for at least five (5) years or the player's 18<sup>th</sup> birthday, whichever occurs last.

Club Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 League Name: \_\_\_\_\_

I hereby consent to the above-named club registering me with US Club Soccer. I understand that I may be registered to only one US Club Soccer member club at any time. [Note: it will not be necessary to complete this form again as long as the player is with this club, which will hold this form unless requested by US Club Soccer.]

Player's Signature \_\_\_\_\_ Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### PLAYER'S MEDICAL INFORMATION

Player's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender:  Female  Male  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email Address: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Bus Phone: ( ) \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ Receive texts?  Yes  No  
 Parent Name: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_ Bus Phone: ( ) \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ Receive texts?  Yes  No

#### In an emergency when parent/guardian cannot be reached, please contact the following:

Name: \_\_\_\_\_ Phone 1: ( ) \_\_\_\_\_ Phone 2: ( ) \_\_\_\_\_  
 Name: \_\_\_\_\_ Phone 1: ( ) \_\_\_\_\_ Phone 2: ( ) \_\_\_\_\_

Please list Allergies the player has:

Please list other medical conditions:

Physician \_\_\_\_\_ Phone 1 ( ) \_\_\_\_\_ Phone 2 ( ) \_\_\_\_\_  
 Medical/Hospital Insurance Company \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
 Policy Holder's Name \_\_\_\_\_ Policy Number \_\_\_\_\_

### MEDICAL TREATMENT AUTHORIZATION AND LIABILITY WAIVER

I hereby give my consent to have an athletic trainer, coach, team manager, emergency medical technician, nurse, medical treatment facility, and/or doctor of medicine or dentistry or associated personnel provide the applicant/participant with medical assistance and/or treatment and agree to be financially responsible for the cost of such assistance and/or treatment. I understand treatment for injury will be based on information provided herein. I hereby authorize emergency transportation of the applicant/participant to a medical treatment facility should an individual listed above consider it to be warranted. I recognize the possibility of physical injury associated with soccer, and hereby release, discharge, and otherwise indemnify the club, US Club Soccer, their sponsors, the USSF and its affiliated organizations, and the employees and associated personnel of these organizations, against any claim by or on behalf of the soccer player named above as a result of that player's participation in US Club Soccer programs and/or being transported to or from the same, which transportation I hereby authorize.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Relation to player:  Father  Mother  Guardian



## Baltimore Bays Tryout Information Form

Please print clearly    Seasonal Year 2013/14    Date \_\_\_\_\_

Bays Team Trying Out For \_\_\_\_\_

Player Name \_\_\_\_\_ Position \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Player Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_      Age \_\_\_\_ B \_\_\_\_ G \_\_\_\_

Player home Phone Number \_\_\_\_\_

Known Medical Conditions \_\_\_\_\_

Father/Guardian Name \_\_\_\_\_

Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Father/Guardian Cell Phone Number \_\_\_\_\_

Father/Guardian E-mail \_\_\_\_\_

Mother/Guardian Name \_\_\_\_\_

Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mother/Guardian Cell Phone Number \_\_\_\_\_

Mother/Guardian E-mail \_\_\_\_\_



# MEDICAL RELEASE FORM



As the parent/legal guardian of \_\_\_\_\_, I request that in my absence the above-named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors 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. 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.

Date of Players Birth      /      /       
Month Day Year

Date of last Tetanus Booster      /      /       
Month Day Year

Known allergies of this player, including any allergies to medicine \_\_\_\_\_

Any other medical problems which should be noted \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (FAX) \_\_\_\_\_

Person responsible for charges (if different from above) \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (FAX) \_\_\_\_\_

Person to notify if parent/guardian is unavailable \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (FAX) \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

### WAIVER

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 the 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.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

### NOTARY PUBLIC

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

Sworn to and subscribed before me on the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

Notary Public in and for the State of \_\_\_\_\_

Commission expires \_\_\_\_\_