

USYSA Membership Form

New Hampshire Soccer Association



FOR OFFICIAL USE ONLY

FOR LEAGUE USE ONLY

- Transfer
- New
- Reregistration
- Change / Correction

League Name _____ Group _____ Div _____

PLEASE PRINT FIRMLY AND LEGIBLY

Member Social Security Number required for Insurance Purposes

- -

Shirt	
Short	

Last Name _____ First Name _____ Mid Int _____ Male/Female _____

Address _____ Birth Date _____ Player=P _____ Coach=C _____ Coach's Lic. Lev. _____
Month / Day / Year Administrator=A _____

City/Town _____ State _____ Zip Code _____ Area Code _____ Tele Numb _____

Father's Name _____ Telephone _____

Mother's Name _____ Telephone _____

List any medical problem or prohibition player has _____

Person to notify in emergency _____ Telephone _____

Doctor to notify in emergency _____ Telephone _____

Number of prior seasons played _____ Last Team _____ Last League _____ Date of Last Season _____ 19____

Height _____ Weight _____ School _____ Grade _____

I, the parent/guardian of the registrant, a minor, agree that I and the registrant will abide by the rules of 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.

NAME _____ Parent / Legal Guardian (Please Print) _____ E-mail address _____

Signature _____ Date _____

CONSENT FOR MEDICAL TREATMENT (MINOR)

As the parent or 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 / Guardian _____

Address _____

City _____ State _____ Zip _____

Phone Home _____ Bus _____

PARENTAL SUPPORT

We ask for active participation of all parents in our programs. Check area(s) in which you would be willing to help.

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Coach | <input type="checkbox"/> Special Projects | <input type="checkbox"/> Fund Raising |
| <input type="checkbox"/> Asst. Coach | <input type="checkbox"/> Field Preparation | <input type="checkbox"/> Referee |
| <input type="checkbox"/> Team Manager | <input type="checkbox"/> Board Member | <input type="checkbox"/> Newsletter |
| <input type="checkbox"/> Team Parent | <input type="checkbox"/> Publicity | <input type="checkbox"/> Donor |
| <input type="checkbox"/> Other Areas _____ | | |

OFFICIAL USE ONLY Picture Received? Yes No
 Birth Date Verified? Yes No

Registration Fee:
 TOTAL _____ Received by _____
 Cash Check No. _____ Date _____