



# EASTERN DISTRICT DIVISION ONE ASSOCIATION INDIVIDUAL PLAYER MEMBERSHIP FORM

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



TEAM	Team Name: _____	Team Number: _____
	Age Group: _____	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 _____ ZipCode _____
	Mother's Name: _____ Home Phone: _____ Daytime Phone: _____
	Father's Name: _____ Home Phone: _____ Daytime Phone: _____
	<b>UNIFORMS INFORMATION</b> 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 appropriate 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: _____