

US Youth Soccer Player Membership Form
OHIO YOUTH SOCCER ASSOCIATION NORTH
LaGrange Youth Soccer Association

League Name: _____ **Age Group:** _____ **Male/Female:** _____

Club/Team Name: _____ **Player ID #:** _____

First Name: _____ **M.I.:** _____ **Last Name:** _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Home Phone Number:** _____ **Birth Date:** _____

Email: _____ **Mother's Month & Day of Birth (Required):** _____

Mother's Name: _____ **Mother's Cell Phone:** _____
(First Name; Include Last Name if different from Player)

Father's Name: _____ **Father's Cell Phone:** _____
(First Name; Include Last Name if Different from Player)

Last Club Team Played On: _____ **Primary or Secondary Team:** _____ **(Required)**
(State Cup teams should always be primary)

WAIVER OF LIABILITY:

By checking one of the boxes below, I the parent/guardian for the above child release, discharge and/or otherwise indemnify the organization/league/club for which I am registering the child to play, US Youth Soccer, the Ohio Youth Soccer Association North, its affiliated sponsors, employees and associated personnel, including the owners of fields and facilities utilized against any claim by or on behalf of the registrant as a result of his or her participation.

(Agreement for Electronic Submission) By checking this box and submitting this e-Registration form, I acknowledge that: I am the parent/guardian authorized to consent on the player's behalf; I have reviewed this form and the information it contains and represent that it is accurate; and I agree to submit this form electronically with the intent to be bound by its terms and conditions.

By checking this box, I acknowledge that: I am the parent/guardian of the player authorized to consent on the player's behalf; I have reviewed this form and the information it contains and represent that it is accurate; and I have opted to print this form, sign it, and return it by mail, instead of submitting electronically.

Parent/Guardian Signature: _____ Date: _____

GENERAL CONSENT FOR MEDICAL TREATMENT:

By checking one of the boxes below, I give my consent to have an athletic trainer, coach paramedic, and/or doctor of medicine or dentistry provide medical assistance and/or treatment. I agree to be financially responsible for the reasonable cost of such assistance and/or treatment. This consent does not apply to major surgery unless surgery must be performed to treat an emergency condition. Attempts will be made to contact parents of players participating in the program based on information provided on this form.

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Parent/Guardian Signature: _____ Date: _____

LYSA is run by parent volunteers, this is not a city-run program. Your participation is crucial for the continued success of this program. Please volunteer for one of the following positions. No experience required.

Coach _____ Asst. Coach _____ Board Member _____ Fundraising _____ Picture Day _____ Filed Maintenance _____

LYSA USE ONLY: Date paid _____ Amount paid _____ Payment Type: CASH PAYPAL CHECK # _____