



# INDIVIDUAL MEMBERSHIP FORM

## South Texas Youth Soccer Association

Fees Paid \_\_\_\_\_



**United States  
Youth Soccer Association**  
 Youth Division of the United  
 States Soccer Federation (USSF)  
 Internationale de Football  
 Association (FIFA)

Team Code:  Assn.  Club  Level  Sex  Age  Team No.

Team Name \_\_\_\_\_ Age Group \_\_\_\_\_  
 I.D.# \_\_\_\_\_

Use Birth Certificate Names Only  
 Last \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_ Nickname \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_ Daytime Phone for Adults (\_\_\_\_) \_\_\_\_\_  
 Date of Birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
 Verified By \_\_\_\_\_ NYCC TEAM  Male  Female  
 Player  Coach  Asst. Coach  Other  Coach's License Level

Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Bus. Phone \_\_\_\_\_  
 Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Bus. Phone \_\_\_\_\_  
 List any medical problem or prohibition player has \_\_\_\_\_  
 Person to notify in emergency \_\_\_\_\_ Telephone \_\_\_\_\_  
 Doctor to notify in emergency \_\_\_\_\_ Telephone \_\_\_\_\_  
 Number prior seasons played \_\_\_\_\_ Last Team \_\_\_\_\_ Last League \_\_\_\_\_ Date of Last Season \_\_\_\_\_ 19\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

		YOUTH				ADULT				Other Children From Family Presently in League	
SHIRTS:	XS S M L XL	XS S M L XL	XS S M L XL	XS S M L XL	_____	_____	_____	_____	_____	_____	Age _____
SHORTS:	XS S M L XL	XS S M L XL	XS S M L XL	XS S M L XL	_____	_____	_____	_____	_____	_____	Age _____
SOCKS:	XS S M L XL	XS S M L XL	XS S M L XL	XS S M L XL	_____	_____	_____	_____	_____	_____	Age _____

I, the parent/guardian of the registrant, a minor, agree that I and the registrant will abide by the rules of the USTSA, 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 \_\_\_\_\_ Parent/Legal Guardian (please print)  
 Signature \_\_\_\_\_ X \_\_\_\_\_ Date \_\_\_\_\_

### PARENTAL SUPPORT

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

<input type="checkbox"/> Coach	<input type="checkbox"/> Committee
<input type="checkbox"/> Asst. Coach	<input type="checkbox"/> Referee
<input type="checkbox"/> Team Manager	<input type="checkbox"/> Fund Raising
<input type="checkbox"/> Team Parent	<input type="checkbox"/> Clerical
<input type="checkbox"/> Special Projects	<input type="checkbox"/> Reporter
<input type="checkbox"/> Field Preparation	<input type="checkbox"/> Newsletter
<input type="checkbox"/> Board Member	<input type="checkbox"/> Concessions
<input type="checkbox"/> Publicity	<input type="checkbox"/> Donor

Other \_\_\_\_\_

### CONSENT FOR MEDICAL TREATMENT (MINOR)

As the parent or legal guardian of the above-named player, I hereby give 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 or Guardian  
 X \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Home \_\_\_\_\_ Bus. \_\_\_\_\_

**OFFICIAL USE ONLY**      Picture Received  Yes  No  
    Birthdate Verified  Yes  No

**Registration Fees:**  
 Player Fee \_\_\_\_\_ \$ \_\_\_\_\_  
 Coach's Fee \_\_\_\_\_ \$ \_\_\_\_\_  
 Other \_\_\_\_\_ \$ \_\_\_\_\_

Received By \_\_\_\_\_  
 Date \_\_\_\_\_

TOTAL \$ \_\_\_\_\_  
 Cash \$ \_\_\_\_\_  
 Check No. \_\_\_\_\_ \$ \_\_\_\_\_

**EMAIL:**



## MEDICAL RELEASE FORM

As the parent/guardian of \_\_\_\_\_, I request that in my absence the above 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.

Birth Date of Player \_\_\_/\_\_\_/\_\_\_ Date of last Tetanus Booster \_\_\_/\_\_\_/\_\_\_

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

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

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

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

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

Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ FAX \_\_\_\_\_

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

Address \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ FAX \_\_\_\_\_

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

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ FAX \_\_\_\_\_

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