



REGISTRATION/MEMBERSHIP FORM FT. LOWELL SOCCER CLUB, INC.



Team Name _____ Age Group U- _____

USE CODE ONLY → - - - -

District League Club Team Player

Recreational = R
Competitive = C

Please print legibly (Full name as it appears on Birth Certificate — **NO NICKNAMES.**)

Last Name _____ First Name _____ Initial _____

Address _____ City _____

State _____ Zip Code _____ Area Code _____ Telephone Number _____ Month/Day/Year Birthdate _____ Male=M Female=F

E-Mail Address _____

Prior Years Played _____ Prior Club _____

Returning Coach/Team _____

Name of School _____ Grade _____

Father's Name _____ Occupation _____ Phone _____

Mother's Name _____ Occupation _____ Phone _____

Legal Guardian _____ Occupation _____ Phone _____

List any medical problems or prohibition of player _____

Person to notify, other than parent(s) in emergency _____ Phone _____

Doctor's name and phone number _____ Phone _____

I, parent or guardian of the registrant, a minor, agree that the registrant and I 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 organization 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.

Print Name _____ Date _____

Signature _____

WE NEED YOUR HELP!!!

Ft. Lowell is a volunteer organization. Please sign up to help continue to make it successful for our players:

<input type="checkbox"/> Coach	<input type="checkbox"/> Asst. Coach
<input type="checkbox"/> Team Mgr/Parent	<input type="checkbox"/> Board
<input type="checkbox"/> Referee	<input type="checkbox"/> Sponsor
<input type="checkbox"/> Shootout Committee	

Ft. Lowell Shootout/Jr. Olympics: All Ft. Lowell SC Families are required to work 2 hrs. at the Shootout. These are volunteer hours.

Signature _____

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 _____

Address _____

City _____ State _____ Zip _____

Phone _____ Work _____

MEDICAL RELEASE NOTARY

(Recommended for In-State play, Required for out-of-state)

Subscribed and sworn to me this day of,

_____ Day Month Year

My Commission Expires: _____

Payment: Cash/Amount _____ Check #/Amount _____ Credit Card/Amount _____

Credit Card Number _____ Expiration Date _____

Birth Certificate: Y N Required Signatres: Y N Returning Player (BC): Y N Player Age Group _____