



DURANGO YOUTH SOCCER ASSOC. MEMBERSHIP FORM



OFFICIAL USE ONLY
DURANGO UNITED

TEAM NAME _____ AGE GROUP _____ CYS PLAYER # _____

Player Last Name: _____ First Name: _____ Init: _____

Player Birth Date: ____/____/____ Sex: M= Male _____ F= Female _____ Fall School: _____ Fall Grade: _____

Primary Guardian: First Name: _____ Last Name: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell or Business: (____) _____

Secondary Guardian: First Name: _____ Last Name: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell or Business: (____) _____

PARENTAL SUPPORT: We ask for active participation of all Parents in our program: check areas you'd help with.
Coach _____ Assist. Coach _____ Referee _____
Team Manager _____ Board Member _____

Other Children from Family Participating In DYSA
____ Age: _____
____ Age: _____
____ Age: _____

PARENT'S APPROVAL

Recognizing the possibility of physical injury associated with soccer, and inconsideration for the USYSA accepting the registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge, and/or otherwise indemnify 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.

Parent acknowledges notice of the following yearly expenses: Player Membership fee (based on age group), Uniform fee, Tournament fees, and Family Volunteer Deposit.

Parent/Guardian name (print) _____ Signature: _____ Date _____

MEDICAL RELEASE and CONSENT TO TREAT

As the parent/legal guardian of the above named player, I request that in my absence this player be admitted to any hospital or medical facility for diagnosis and treatment for emergency medical care. 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.

Date of last Tetanus Booster ____/____/____

Known allergies of this player, including allergies to medications: _____

Any other medical problems which should be noted: _____

Family Physician: _____ Phone: _____

Person Responsible for Charges if different from above: _____

Address: _____ City _____ State _____ Zip _____

Person to Notify if Parent/Guardian is Unavailable: _____

Phone H _____ W _____ Cell _____

Insurance Carrier _____ Policy # _____

Parent/Guardian name _____ Signature _____ Date _____

Official Use: PAID: Amount: _____ Check # _____ Date: _____