

Mail to: LYSA • PO Box 20, La Crescent, MN 55947

Or bring to LYSA Soccer Fair 1/23/10 @ Fire Station Community Room 9 a.m. to noon

PLEASE PRINT CLEARLY

PARTICIPANT'S FIRST NAME _____ M.I. _____ LAST NAME _____

ADDRESS _____ CITY/STATE _____ ZIP _____

AREA CODE TELEPHONE NUMBER _____ MO / DAY / YEAR _____ MALE /
BIRTHDATE _____ FEMALE _____

CHECK HERE IF NEW ADDRESS

SCHOOL _____

T-SHIRT SIZE (CIRCLE ONE)
(YS / YM / YL / YXL / AS / AM / AL / AXL)

FATHERS NAME (GUARDIAN) _____ WORK/CELL PHONE NUMBERS _____

MOTHERS NAME (GUARDIAN) _____ WORK/CELL PHONE NUMBERS _____

PRIMARY EMAIL _____ SECONDARY EMAIL _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY _____ PHONE NUMBER _____

DOCTOR TO NOTIFY IN CASE OF AN EMERGENCY _____ PHONE NUMBER _____

LIST ANY MEDICAL PROBLEMS OR PROHIBITIONS PLAYER MAY HAVE _____

PLAYER / PARENT SUPPORT: We ask for active participation in our program. Please check area(s) in which you can help:

- Coach/Assistant Apparel/Spirit Wear Team Parent Rep Field Preparation
 Fundraising Equipment/Uniforms Referee (training provided) Board Member

**** IMPORTANT ****

I, the parent/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 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 or on the behalf of the registrants a result of the registrant's participation in the Programs and/or being transported to or from the same, which transportation I here authorize.

Print Name _____ Date _____
 Parent/Legal Guardian (Please Print)

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 of Parent/Guardian _____ Date _____

For league use ONLY

Date: _____

Registration Fee paid:	\$ _____	(\$35 for U5-U7, \$70 for U8+)
+ Indoor Soccer Fee (U6-U12)	\$ _____	(optional \$35)
+ other items ordered:	\$ _____	(optional)
+ _____	\$ _____	
= Check Total	\$ _____	Check #: _____