

**Greene County Soccer Association  
Registration Form  
Fall 20\_\_\_\_ & Spring 20\_\_\_\_**

**Fall Only\_\_\_\_\_**

**PLAYER INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Telephone # (w/area code) \_\_\_\_\_

Birthday \_\_\_\_\_ Male or Female \_\_\_\_\_

Father's Name \_\_\_\_\_ Bus. Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Bus. Phone \_\_\_\_\_

List any medical problem or prohibition player has \_\_\_\_\_

Person to notify in case of emergency \_\_\_\_\_

Doctor to notify in case of emergency \_\_\_\_\_

Number of Seasons played \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Uniform Size (Circle appropriate size)  
 Youth                      Adult  
 Shirt    S    M    L              Shirt    S    M    L    XL  
 Shorts   S    M    L              Shorts   S    M    L    XL

**Parental Support**  
 This program functions because of continued participation of parents. Please circle areas in which you are willing to assist:  
 Coach                      Asst. Coach  
 Referee                     Board Member  
 Sponsor                     Other \_\_\_\_\_

**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 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 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 \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT (MINOR)**

As the parent or legal guardian of the above-signed 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 \_\_\_\_\_ Official Use Only

X \_\_\_\_\_

Player(s) Fee    \$40

Address \_\_\_\_\_

Received by \_\_\_\_\_

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

League   U-6B   U-6G   U-8B   U-8G

Phone: Home \_\_\_\_\_ Bus. \_\_\_\_\_

U-10    U-12    U-14    U-16

Make Checks Payable to GCSA, PO Box 1282, Paragould AR 72450