



# COPPELL YOUTH SOCCER ASSOCIATION

P.O. Box 354, Coppell, Tx 75019-0354, (972-304-0886)

## Academy Only/Non-Rostered Player Registration Form

Player's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Player's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Player's Home Phone: \_\_\_\_\_ Sex: \_\_\_\_\_ Birth: \_\_\_\_\_ Registration Number: \_\_\_\_\_

Main E-Mail: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Birth Certificate on File: \_\_\_\_\_

Guardian #1 Name: \_\_\_\_\_ Guardian #1 Home Phone: \_\_\_\_\_

Guardian #1 Work Phone: \_\_\_\_\_ Guardian #1 Mobile Phone: \_\_\_\_\_

Guardian #2 Name: \_\_\_\_\_ Guardian #2 Home Phone: \_\_\_\_\_

Guardian #2 Work Phone: \_\_\_\_\_ Guardian #2 Mobile Phone: \_\_\_\_\_

Academy Club Affiliation: \_\_\_\_\_ Academy Team Name: \_\_\_\_\_

Fee: \_\_\_\_\_ Amount Paid: \_\_\_\_\_ Method: \_\_\_\_\_ Check #: \_\_\_\_\_

### RELEASE OF LIABILITY (must be signed)

I, the parent/guardian of the registrant minor, agree that I and the registrant will abide by the rules and regulations of the USYSA, its affiliated organizations and its sponsors ("USYSA Parties"). In consideration of the player's participations in the soccer programs and activities of the USYSA Parties (the "Programs"). I, for myself and the player and our respective heirs, administrators and successors, intending to be legally bound, hereby release and indemnify the USYSA Parties, the owners and operators of the facilities used for the Programs, and their respective directors, officers, employees, agents, and representatives from and against all claims, liabilities, damages, or causes of actions arising out of, or in connection with, the player's participation in he Programs including, without limitation, player's transportation to/from any Program which transportation is hereby authorized.

**X** \_\_\_\_\_  
Name (printed) Signature Date

### CONSENT FOR MEDICAL TREATMENT (must be signed)

As the parent or legal guardian of the above named player, I hereby give consent for emergency medical care prescribed by the 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.

**X** \_\_\_\_\_  
Name (printed) Signature Date

**NOTE: There will be a \$25 service fee for NSF checks.**

### 2010 - 2011 CYSA Registration Fees

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#### CYSA Academy Only Player Fees:

Fall and Spring (\$90): \_\_\_\_\_  
(includes \$10 form fee per season)

Spring Only (\$80): \_\_\_\_\_  
(includes \$10 form fee for Spring season)

### FOR CASHIER USE ONLY

Check Amount: \_\_\_\_\_ Cash Amount: \_\_\_\_\_ Charge Amount: \_\_\_\_\_  
Received By: \_\_\_\_\_ Received By: \_\_\_\_\_ Approval Code: \_\_\_\_\_  
Date: \_\_\_\_\_ Date: \_\_\_\_\_ Received By: \_\_\_\_\_  
Check #: \_\_\_\_\_ Date: \_\_\_\_\_