



INDIVIDUAL MEMBERSHIP FORM

Arroyo Youth Soccer Club

607 N. 77 Sunshine Strip - PO Box 455 - Harlingen, TX 78551

956-428-3622

www.haysc.com



United States Youth Soccer Association

Youth division of the United States Soccer Federation (USSF)
Internationale de Football Association (FIFA)

Team Name _____ Age _____
 Group _____

Please Print Firmly and Legibly To Make Clear Multiple Copies.

Use Birth Certificate Names Only _____
 Last First Initial Nickname

Mailing Address _____
 Street/Box No. City Zip

Contact Phone _____ Contact Phone _____

Date of Birth _____ Verified By _____
 Month Day Year

Male Female

SHIRT SIZE
 Youth Adult
 S M L S M L

Father's Name _____ Email _____
 Mother's Name _____ Email _____

List any medical problem or prohibition player has _____

Person to notify in emergency _____ Telephone: _____
 Doctor to notify in emergency _____ Telephone: _____

Number prior seasons played _____ Last Team _____ Last League _____ Date of Last Season _____ 20____
 School _____ Grade _____

Other children from family presently in AYSC:
 _____ Age _____
 _____ Age _____

I, the parent/guardian of the registrant, a minor, agree that I and the registrant will abide by the rules of the USYSA, AYSC, its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration for the USYSA and AYSC accepting the registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify the USYSA, AYSC, 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 _____
 Signature _____ Date _____

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.

X _____
 Signature of Parent or Guardian

FOR OFFICIAL USE ONLY

Registration Fees: Cash
 Check # _____
 CC Appr. # _____
 Receipt # _____

Player's Fee \$ _____
 Amount Paid \$ _____
 Balance Due \$ _____

PARENTAL SUPPORT
 We ask for active participation of all parents in our program. Check area(s) in which you would be willing to help.

Coach Board Member Reporter
 Asst. Coach Publicity Newsletter
 Team Manager Committee Concessions
 Team Parent Referee Donor
 Special Projects Fund Raising
 Field Preparation Clerical
 Other _____

Fall / Spring Registration
 Yearly Registration
 Other Program _____ Received By _____ Date _____

Comments: _____

