CHICO YOUTH SOCCER LEAGUE - PLAYER REGISTRATION FORM

Mailing Address: CYSL, P.O. Box 1537, Chico, CA 95927 League Phone: 894-1088 Fax: 894-8889
E-Mail: soccercysl@gmail.com Web Site: www.cyslsoccer.com

FEE: $100 per player **LATE FEE:** $130 *after* Dec. 31st for Spring Season or *after* July 31st for Fall Season

MAKE CHECKS PAYABLE TO: CYSL

PLAYER INFORMATION - PLEASE PRINT LEGIBLY (this info. will be on team roster) SPRING _____ FALL _____

Player Name:____ Returning Player _____ New to CYSL_____

Address: ____ City/Zip: ____________________________

Primary Contact Phone: ________________________ Age:____ Birthdate:________________ Sex: Male___ Female___

PARENT INFORMATION - PLEASE PRINT LEGIBLY

Father/Guardian:____ Phone:____________________________

Address: ____ Work Phone: _______________________

City/Zip: _____________________________________ Email:____

Mother/Guardian:____ Phone:____________________________

Address: ____ Work Phone: _______________________

City/Zip: _____________________________________ Email:____

I AM INTERESTED IN:

Father/Guardian:	☐ Head Coach	☐ Asst. Coach	☐ Board Member	☐ Referee	☐ Sponsor	☐ Team Helper
Mother/Guardian:	☐ Head Coach	☐ Asst. Coach	☐ Board Member	☐ Referee	☐ Sponsor	☐ Team Helper

UNIFORM

Please Note: A T-Shirt is provided for all participating players. Players will need to purchase: ALL BLACK SHORTS, shin guards, and solid-colored socks to match the T-Shirt. (No white or colored stripes on shorts or stripes on socks.)

IMPORTANT: PLEASE READ AND SIGN FOR BOTH LEGAL STATEMENTS BELOW

1. I, the parent or legal guardian of ________________________ hereby agree to allow the minor to participate in the activities of the Chico Youth Soccer League, and I agree to indemnify and hold it, its officers, employees and affiliated personnel harmless from and defend against, any and all liability for any manner connected with participation in the Chico Youth Soccer League. I hereby agree not to hold the CYSL responsible for any medical expense incurred as the result of the minor's participation in any of its activities.

CONSENT FOR MEDICAL TREATMENT (MINOR)

2. I, the parent or legal guardian of _______________________ hereby give my 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.
Special information for allergies or medication: ____

PARENT/GUARDIAN SIGNATURE: _____________________________________ **Date:** ____________________

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LEAGUE USE ONLY

Check #:_________ **Amount Received:**___________ **Date:**_____________ **Birthdate:**__________ **Verified By:**__________

White Copy – League Yellow Copy – Participant