Burlington Youth Soccer Association

MYSA/USYSA

Membership Form

Player's First Name:	Player's Last Name:	Gender (circle one): M / F	Date of Birth: (MM/DD/YY) / /

Street:	City:	State:	Zip Code:

School :	Current Grade:

Travel Uniforms: (Circle one each group) *(Note: "YL" is Youth Large, "AS" is Adult Small, etc.)*:

Shirt: YS YM YL AS AM AL AXL **Shorts**: YM YL AS AM AL AXL

Parent / Guardian 1 – Name:

Home Phone:	Cell Phone:	Work Phone:	E-Mail:

I would like to volunteer as: (Circle all that apply) Coach / Asst Coach
(Note: You will be contacted by BYSA BOD for additional information and CORI instructions)

Parent / Guardian 2 – Name:

Home Phone:	Cell Phone:	Work Phone:	E-Mail:

Emergency Contact Name:	Emergency Contact Phone Number:
Doctor's Name:	Doctor's Phone Number:

Does your player have any medical conditions we should be aware of? If none, please write "NONE."

Parent/Guardian Signature:_____ Date: _____

Your signature indicates that you agree with the attached; Liability Release, Medical Consent and that all the data entered by you is correct.

LIABILITY RELEASE: I, the parent/guardian of the above named registrant, a minor, agree that I and registrant will abide by the rules of MYSA, the USYSA, its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration for the MYSA/USYSA accepting the registrant for its soccer programs and activities (the "Program"), I hereby release, discharge and/or otherwise indemnify MYSA/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.

MEDICAL CONSENT: As parent or legal guardian of the above-named player, I 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 life, limb, or well-being of my dependent.

Please make any necessary corrections to the above information, sign and date this form

Enclose payment (payable to BYSA) and return to your coach or to: BYSA, P.O. Box 213, Burlington, MA 01803

Registration Fees:

$60 (U6) $75 (U8) $100 Travel (U9 - U14) $100 Travel (U16 - U19)

$25 Late Fee for U9 - U14 if received After June 23 (for Fall Season) or Dec. 1 (for Spring Season)

BYSA USE ONLY ***Age Group_____***

Fee: _____Late Fee: _____Total Fee:_____ Check #: _____ Rec'd by: _____Date: _____