



THOMPSON SOCCER ASSOCIATION
 1217 W. Eisenhower, Loveland, CO 80537
 (970) 461-9358 www.thompsonsoccer.com
 Tania Newgord, District Commissioner

Date _____
 Team _____
 Office copy
 Coaches copy
 Treas. Copy

Last Name _____ First Name _____
 Birthdate _____ Phone _____ School _____
 Email: _____
 Address: _____ City _____
 Zip _____ Gender: M F (circle one) Grade _____

Registration (\$85.00)
 Paid \$ _____
 Uniform (\$30.00)
 Paid \$ _____
 YM YL AS AM AL
 AXL
 Received: YES NO
 Paid by: CK Visa
 MC
 Ck # _____
 Received
 by: _____

Fathers Name: _____ Occupation: _____ Bus Phone _____
 Mother's Name: _____ Occupation: _____ Bus. Phone _____
 List any medical problems or prohibition player has: _____
 Person to Notify in Emergency: _____ Phone: _____
 Doctor to notify in emergency: _____ Phone: _____

PARENTAL SUPPORT – check any areas in which you would be willing to help:

Coach Assist Coach Team Parent Board Member Fund Raising Fields Referee
 OTHER _____

Important

I, the parent/guardian of the registrant, a minor, agree that I and the registrant will abide by the rules of the CYC, its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration for the CYC accepting the registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify the CYC, its affiliated organizations and sponsors, their employees and associated personnel, including the owners of the field 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 authorized.

NAME _____
 Parent/Legal Guardian (please print)

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 and well being of my dependant.

Signature of Parent or Guardian X _____