WILLARD YOUTH SOCCER CLUB (WYSC)

RECREATIONAL SOCCER Spring 2020 WYSC Use only Div: ____

Last Name_____First Name_____

Age:_____Birth Date:_____M____F____Soccer Experience:_____

Address:_____City_____Z/C_____

Custodial Parents:_____

Home Phone:_____Cell Phone_____

Email:_____

Coach Name or team play last season;_____

Players Shirt Sizes: (Circle One) Youth: S M L **Follow our page in Facebook For Future Announcements :**

Adult: S M L XL **Willard Soccer League**

Age: 4-6 years old, 7-9 years old, 10-12 years old, 13 to 15 yr.

Registration Fee: $45.00 (No Refunds)

Please Make Check payable To: WILLARD SOCCER LEAGUE Payments Mail To: 111 Woodbine Avenue Willard Ohio 44890

For More Information Call: Emmanuel Esparza 419-677-8569 Email: willardsoccerleague1@gmail.com

Games Starts March, 23.2020 Practice May Start Mar 9 . UP TO COACHES

Date Line For Registration: Mar,16 (Practice could be start late or early depending on how fast kids join)

Player Waiver Form

I hereby grant permission for the above child to participate in the WYSC, Including practice and games recognizing that participating will involve competitive physical activity. Voluntarily assume the risk of Injury to your child. I Hereby waive and release the WYSC and He's Offices Board, Members, Volunteers, And Owners of the fields and Facilities utilized, Director of WYSC from claims or liabilities which might have as a result of participation I Further agree that the child all parents or guardians of said child will adhere to and abide by the club rules and character.

Parents Name_____ Parents Signed_____Date_____

Emergency Medical Authorization

I, The Parent or Guardian give permission for treatment of a minor illness or injury after reasonable attempt to contact myself af the Emergency
Contact listed below. My preferred Physician and Dentist are listed below, they are unavailable or are not designated. A qualified local Physician or Dentist will be contacted. I further agree to be financially responsible for any and all costs Incurred. list below any Facts concerning the child's medical History Including allergies, Medication and Physical Impairments or limitations to which the Coach or Physician should be aware. Medial Heston/Allergies.

Physician Name_____Phone_____

Dentist Name_____Phone_____

Emergency Contact #1_____Phone_____

Emergency Contact #2_____Phone_____

Signed_____Relationship_____Date_____