

ODP State Selection – Mail In Registration Form



Player's Last Name:		Player's First Name:	Middle Initial:
Mailing Address:		City/State/Zip Code:	Home Ph #:
Player's Email Address:		Player's Cell #:	Birth Date (MM/DD/Year):
Position: <input type="checkbox"/> FIELD PLAYER <input type="checkbox"/> GOALKEEPER	Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Player's T-Shirt Size: (select youth or adult size) <input type="checkbox"/> Yth Lrg <input type="checkbox"/> Adlt Small <input type="checkbox"/> Adlt Med <input type="checkbox"/> Adlt Lrg <input type="checkbox"/> Adlt X-Lrg	
Father/Guardian's Name:		Father/Guardian's Email Address:	Father/Gurardian's Cell #:
Mother's Name:		Mother's Email Address:	Mother's Cell #:
Person to Notify in Emergency:			Phone #:
Physician to Notify in Emergency:			Phone #:

IMPORTANT

I, the parent/guardian of the registrant, a minor, agree that I, and the registrant will abide by the rules of the United States Youth Soccer, and its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration for the United States Youth Soccer accepting the registrant for its programs and activities(the "Programs"), I hereby release, discharge, and/or otherwise indemnify the United States Youth Soccer, 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 registrants participation in the Programs and/or being transported to or from the same, which transportation I herby authorize.
 (For all ODP Events through July 31, 2012)

NAME:	
Print Name of Parent/Legal Guardian	
SIGNATURE:	DATE:

Consent for Medical Treatment

As the parent or legal guardian of the registered 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 wellbeing of my dependant. (For all ODP events through July 31, 2012)

NAME:	
Print Name of Parent/Legal Guardian	
SIGNATURE:	DATE:

Make check payable to "HYSA". Mail completed form and payment to: HYSA ODP, 1161-E Wainiha Street, Honolulu, HI 96825