

USYSA Membership

WISCONSIN YOUTH SOCCER ASSOCIATION

For League Use Only

- Transfer
- New
- Registration
- Change/Correction



Youth Division of the United States Soccer Federation (USSF)
 Affiliated with the Federation Internationale de Football Association (FIFA)

League Name: East Central Age Group: [Redacted]

Club/Team Name: Oshkosh United

(Use Code Only) Region: 02 State: WI District: 004 League: 004 Club: 057 [Redacted] Recreational = R Competitive = C

PLEASE TYPE OR PRINT FIRMLY AND LEGIBLY.

Last Name: _____ First Name: _____ Init.: _____

Address: _____ City: _____

State: WI Zip Code: _____ Area Code: _____ Telephone Number: _____ Month: _____ Day: _____ Year: _____ Male = M Female = F Player = P Coach = C License Level: [Redacted]

Father's Name _____ Occupation _____ Bus. Phone _____

Mother's Name _____ Occupation _____ Bus. Phone _____

List any medical problem or prohibition player has _____

Person to notify in emergency _____ Telephone _____

Doctor to notify in emergency _____ Telephone _____



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Important

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

Name _____ Parent/Legal Guardian (please print)

Signature X

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 or well-being of my dependent.

Signature of Parent of Guardian

X

Address _____

City _____

State WI Zip Code _____

Home Telephone _____

Business Telephone. _____

OFFICIAL USE ONLY

Picture Received Yes No
 Birthdate Verified Yes No

Registration Fees:

Player Fee \$ _____

Coach's Fee \$ _____

Other \$ _____

TOTAL \$ _____

Cash \$ _____

Check No. \$ _____

Received By _____

Date _____