



FC ARIZONA

Player Registration & Medical Release Form

2024-25

TEAM INFORMATION			
Team Name: _____	Sex: M	F	Age Group: _____
Coach: _____	League: Open League	ASL	APL ECNL DPL

PLAYER INFORMATION			
First Name: _____	Middle Initial: _____	Last Name: _____	
Address: _____	City: _____	State: _____	Zip: _____
Phone Number: _____	DOB: ____/____/____		
Family eMail: _____	Player eMail: _____		

PARENT / LEGAL GUARDIAN	PARENT / LEGAL GUARDIAN / SECONDARY CONTACT
Name: _____	Name: _____
Relationship to Player: _____	Relationship to Player: _____
Cell Phone: _____	Cell Phone: _____
eMail: _____	eMail: _____

I, the parent/guardian of the above-named player agree that the player and I will abide by the rules and regulations of the USYSA and/or US Club Soccer (The Programs), its affiliated organizations and its sponsors. In consideration of the player's participation in the soccer programs and activities of the USYSA and/or US Club Soccer I, for myself and the player and our respective heirs, administrators and successors, intending to be legally bound, hereby release and indemnify the USYSA and/or US Club Soccer, the owners and operators of the facilities used for The Programs, and their respective directors, officers, employees, agents and representatives from and against all claims, liabilities, damages or causes of action arising out of or in connection with the player's participation in the Programs including, without limitation, player's transportation to/from The Programs, which transportation is hereby authorized. I further grant the USYSA Parties and/or US Club Soccer the right to use the player's name, picture and/or likeness in printed, broadcast and other material concerning The Programs provided such use is related to the player's status as a participant in The Programs.

Parent Name (Printed): _____

Signature: _____ Date: ____/____/____

Player Name (Printed): _____

Signature: _____ Date: ____/____/____

CONSENT FOR MEDICAL TREATMENT AND TRANSPORTATION

•As the parent/legal guardian of the above named player, I request that in my absence the above-named player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. This care may be given under whatever conditions are necessary to preserve the life, limb, or wellbeing of my dependent. I have not been given a guarantee as to the results of examination or treatment, but agree to be financially responsible for the cost of such assistance/treatment.

•The undersigned, parent/guardian of the above named player, does hereby authorize any officer, teacher, or coach, agents of USYSA and or US Club Soccer to transport as required the above minor to and from association sponsored activities including, but not limited to athletic and social events.

•Please list any medical conditions, allergies and/or medications:

 Parent/Guardian / Player (Over 18 Years Old) Name: _____

Signature: _____ Date: ____/____/____

MEDICAL RELEASE NOTARY

SUBSCRIBED AND SWORN TO ME THIS DAY OF: ____/____/____

MY COMMISSION EXPIRES: ____/____/____

NOTARY SIGNATURE: _____

NOTARY STAMP