MANCHESTER ANGELS

Manchester Angels Youth Soccer League

PO Box 4673 • Manchester, NH • 03108-4673 • www.MAYSL.org

PLAYER INFORMATION

Last Name:_____ First Name:_____ M_____ F_____

Address:_____ D.O.B. _____

City/Town:_____ ZIP _____ Home Tel:_____

Player or Parent E-Mail Address:_____ Age:_____

Number of Prior Seasons Played:_____ Name of League and Last Season Played:_____

Height:_____ Weight:_____ Travel or High School Level of Play:_____

What School Do You Attend?_____

Any Conflicting Activities in the Spring?_____

U-14 Division or Higher Only: What Positions Do You Play? ☐ Forward ☐ Midfield ☐ Defense ☐ Goalie

PARENT & MEDICAL INFORMATION

Father's Name:_____ Cell Phone:_____ Home Tel:_____

Mother's Name:_____ Cell Phone:_____ Home Tel:_____

List any Medical Problems or Prohibitions Player Has:_____

_____

Person to Notify in Case of Emergency:_____ Cell Phone:_____

Doctor to Notify:_____ Telephone:_____

LEGAL RELEASE

I, the parent/guardian of the registrant if a minor, or the player if over the age of 18 agree that I and the registrant will abide by the rules and regulations of the USYSA and MAYSL, its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration for the USYSA and MAYSL accepting the registrant for its soccer programs and activities, I hereby release, discharge and/or otherwise indemnify the USYSA and MAYSL, 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 registrants a result of the registrants participation in the Programs and/or being transported to or from the same, which transportation do hereby authorize. (Players new to league MUST submit Birth Certificate)

NAME:_____

Parent/Legal Guardian or Player if over the age of 18 years (PLEASE PRINT)

SIGNATURE:_____ DATE:_____

CONSENT FOR MEDICAL TREATMENT

As the parent or legal guardiian, or the registrant if over the age of 18, I hereby give my 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 the

_____

Signature of Parent/Legal Guardian or Adult Registrant

Address:_____

City:_____ State:_____ Zip:_____

Phone-Home:_____ Bus/Cell:_____

VOLUNTEER INFORMATION

We ask for active participation of all parents in our program. Please check any and all areas that you would be willing to participoate.

☐ Coach
☐ Asst. Coach
☐ Team Parent
☐ Re-Lining the Fields
☐ Referee
☐ Sponsor
☐ Board Member

OFFICIAL USE ONLY Birth Date Verified ☐ Yes ☐ No

Registration Fee: Please make all checks payable to *MAYSL*

Total:$_____ Received by:_____

☐ Cash ☐ Check No._____ Date_____/_____/_____