

*East Ridge Soccer Association
Youth Registration Form*

P.O. Box 90034 East Ridge, TN 37412

www.ersoccer.org

**Recreational
Season:
Fall/Spring 07-08**

**FEE: \$70
U4/U6: \$65
Family Maximum:
\$175(siblings only)**

Player: Last name _____ First name _____ M.I. _____

Address _____ **City** _____ **ST.** _____ **Zip** _____

Gender : Male Female **Date of birth** ____/____/____

Father's name _____ **Mother's name** _____ **Home phone:** (____) _____

Occupation _____ **Occupation** _____

E-mail _____

Work phone _____ **Cell Phone** _____ **Work phone** _____ **Cell Phone** _____

of seasons/years played _____ **Is player currently playing select soccer?** _____

Medical problems _____

Person to notify in emergency _____

Phone _____ **Relationship** _____

Doctor to notify in emergency _____ **Phone** _____

WE NEED YOUR HELP!! As the number of children grows at Camp Jordan, so does the need for volunteers. Please circle below the areas you can help.

Coach Asst. Coach Team Parent Will assist team Commissioner

Recognizing the possibility of physical injury associated with soccer and in consideration for TSSA/USYA/ERSA and its affiliates, accepting the registrant for its soccer programs and activities to the extent not covered by insurance programs, I hereby release, discharge and/or otherwise indemnify the TSSA/USYA/ERSA, its affiliated organizations and sponsors, their employees and associated personnel, including the owners of the 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 program and/or being transported to and from the same, which transportation I hereby authorize. My child has received a physical examination by a physician and has been found physically capable of participating in the programs.

Therefore, I grant ERSAs, officials, or coaches permission to act as my surrogate for my child in the area of obtaining medical treatment by a doctor of medicine or dentistry. I also assume the financial responsibility for any medical treatment for my child.

Parent/ guardian Name (print) _____

Parent/ guardian Signature _____ **Date** _____

***No refunds of registration fees will be given after two weeks of the season's first game.**

****\$20 returned check fee in addition to bank charges**

Office Use Only:

Requests:

Application received by: _____
(Print Name)

Cash \$ _____ **Receipt #** _____

Check # _____ **/Amount:** _____

Family Max \$175: Number of Players: _____

of Players @\$65 _____ **# of Players @\$70** _____