

**Indoor Season:
2007-08
Fee: \$75.00
Fam. Max. \$185
Team: \$70.00**

East Ridge Soccer Association
Indoor Youth Registration Form
P.O. Box 90034 East Ridge, TN 37412
www.ersoccer.org

**Are you currently
registered with
Tennessee State
Soccer Association?**
Yes No

Make checks payable to CJIS

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:** _____

Email _____

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

of seasons played _____

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.

Name (print) _____

Signature _____ **Date** _____

No refunds of registration fees will be accepted after 12/15/2007.

Requests
Make checks payable to CJIS
\$20 returned check fee in addition to bank charges~

Cash	Check	Amount
\$ _____	# _____	\$ _____
Receipt # _____	Received by _____	