



Mailing Address: WYSA, P.O. Box 3173, Easton Pa. 18043-3173

### Information for Coach's

\*\*\*\* Please PRINT or write clearly\*\*\*\*

Player's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Alternate forms of communication: (if applicable)

Cell phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

EMAIL: \_\_\_\_\_

Alternate individual to be notified in case of an emergency:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship (to player) \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship (to player) \_\_\_\_\_

Does player have any allergies? (please circle) **Y** **N**  
If yes, please list all related allergic condition(s). Use reverse side if more space is required.

Is player currently taking any medication? (please circle) **Y** **N**  
If yes, please list all prescription medications. Use reverse side if more space is required.

Person(s) authorized to pickup player from practice or games:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Recognizing the possibility of physical injury associated with soccer and in consideration for WYSA and its affiliates accepting the indicated registrant for its soccer program and activities I hereby release, discharge and/or otherwise indemnify WYSA's coaching staff, affiliated organizations and sponsors, their employees and associated personnel against any claim or medical responsibility, by or on behalf of the registrant's participation in said program. I request that in my absence the above-named player be admitted to any hospital or medical facility for diagnosis and treatment 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. I understand that I have not been given a guarantee as to the results of the examination or treatment of my child and every attempt shall be made to contact me via the information listed above. I also assume the financial responsibility for any such medical treatment for my child.

Signature of parent/guardian \_\_\_\_\_ Date: \_\_\_\_\_

(Please sign here)