



ROCK SPRINGS SOCCER ASSOCIATION
P.O.BOX 2553
ROCK SPRINGS, WY 82902-2553

Player Registration Form (Registration fee \$45.00)

Age Bracket: _____ Team #: _____ Previous Coach: _____ Recd By: _____

Player's Last Name: _____ First: _____ MI: _____

Street: _____

Town: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Sex: _____ DOB: _____

Division: _____ Team: _____

Grade: _____ School: _____

Father's Last Name: _____ First: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Father will help with: Team ___ League ___ Referee ___ Other: _____

Email: _____

Mother's Last Name: _____ First: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Mother will help with: Team ___ League ___ Referee ___ Other: _____

Email: _____

Emergency Contact: _____ Phone: _____ Cell: _____

Relationship: _____

Family Doctor: _____ Phone: _____

Tetanus booster current? Yes ___ No ___ Seizures or Convulsions? Yes ___ No ___

Drug Allergies? _____

Other information an attending physician should be aware of: _____

Amt Due:_____ Amt Paid:_____ Method:_____ Fund Raiser:_____

Waiver, Release, and Permission:

I/We hereby make an application for the above named child to be enrolled in the program of the Rock Springs Soccer Association, Inc. (hereafter known as RSSA). Inconsideration thereof, I/We hereby agree to release, absolve, Indemnify, and hold harmless the RSSA, including any of the Clubs' directors, officers, sponsors, and any other supporters of the Club for (1) any injury, risk, and hazards incidental to the conduct of activities, including practice, match, ceremonial functions, and transportation to and from the activities; (2) any harm or distress which may be sustained incidental to conduct and implementation of the Laws of the Game as adopted by FIFA, USSF, USYSA, and WYS and as may be modified for children's play by the RSSA including roster changes, disciplinary action, suspensions, and dismissals from the club; and (3) providing, in the case of an injury requiring immediate medical attention, assistance and/or treatment by a physician, surgeon, paramedic, trainer, or hospital as would ordinarily be given to a patient in such condition. I/We fully assume financial responsibility for such care.

Signed:_____ Date:_____

Special Request:_____