

CK # \_\_\_\_\_

CASH \_\_\_\_\_

SUWANNEE VALLEY LEAGUES INC.  
YOUTH REGISTRATION FORM  
SOCCER

PLAYER'S NAME : \_\_\_\_\_ MALE : \_\_\_\_\_ FEMALE : \_\_\_\_\_

PHYSICAL ADDRESS: \_\_\_\_\_

HOME PHONE # : \_\_\_\_\_ CELL # : \_\_\_\_\_ WORK : \_\_\_\_\_

E-MAIL ADDRESS : \_\_\_\_\_

PLAYER'S D.O.B. : \_\_\_\_\_ RECEIPT OF COPY OF BIRTH CERTIFICATE : YES \_\_\_\_\_ NO \_\_\_\_\_

SHIRT SIZE : YXS(26-28) \_\_\_\_\_ YS(30-32) \_\_\_\_\_ YM(32-34) \_\_\_\_\_ YL( 34-36) \_\_\_\_\_ AS(36-38) \_\_\_\_\_ AM(38-40) \_\_\_\_\_ AL(40-42) \_\_\_\_\_ AXL(44-46) \_\_\_\_\_  
AXXL \_\_\_\_\_

WAIST SIZE : YXS(18-20) \_\_\_\_\_ YS(20-22) \_\_\_\_\_ YM(22-24) \_\_\_\_\_ YL(24-26) \_\_\_\_\_ AS(28-30) \_\_\_\_\_ AM(32-34) \_\_\_\_\_ AL(36-38) \_\_\_\_\_ AXL(40-42) \_\_\_\_\_  
AXXL \_\_\_\_\_

**A UNIFORM WILL NOT BE PURCHASED UNTIL SIGN-UP FEE HAS BEEN PAID AND BIRTH CERT. RECEIVED**

WILL YOU FIND A SPONSOR FOR YOUR TEAM (\$300.00)? YES \_\_\_\_\_ NO \_\_\_\_\_

WILL YOU COACH OR BE AN ASS'T. COACH FOR YOUR TEAM? YES \_\_\_\_\_ NO \_\_\_\_\_ SHIRT SIZE: \_\_\_\_\_

**PRESS RELEASE AUTHORIZATION :** BY MY SIGNATURE BELOW, I AM THE LEGAL PARENT / GUARDIAN OF THE PLAYER NAMED AT THE TOP OF THIS FORM. I AUTHORIZE HIS / HER NAME AND OR PHOTO TO BE PUBLISHED IN THE MEDIA AS DEEMED APPROPRIATE BY THE S.V.L. INC. BOARD MEMBERS.

**MEDICAL TREATMENT INFORMATION :**

BY MY SIGNATURE BELOW, I AM THE LEGAL PARENT / GUARDIAN OF THE PLAYER NAMED AT THE TOP OF THIS FORM. I TAKE RESPONSIBILITY FOR THE CLAIMS HERETOFORE OR HEREAFTER ARISING KNOWN OR UNKNOWN, FROM THE PLAYER'S PARTICIPATION IN THE PROGRAMS OF S.V.L. INC. / G.C.R.A. INC. I KNOWINGLY, VOLUNTARILY AND EXPRESSLY RELEASE THE VOLUNTEERS CONDUCTING THE PROGRAMS AND S.V.L. INC. / G.C.R.A. INC. FROM ALL LIABILITY ON CLAIMS ARISING ON SUCH MATTERS. I FURTHER AUTHORIZE ANY PHYSICIAN, HOSPITAL, OR DENTIST TO PROVIDE ANY EXAMINATION AND / OR TREATMENT FOR THE ABOVE NAMED PLAYER. I WILL BE RESPONSIBLE FOR ALL THE REASONABLE EXPENSES INCURRED FOR SUCH TREATMENT OR MEDICAL CARE BEYOND THE INSURANCE PROVIDED BY S.V.L. INC. / G.C.R.A. INC.

MEDICAL CONDITIONS OR ALLERGIES: \_\_\_\_\_

PHYSICIAN : \_\_\_\_\_ PHONE # : \_\_\_\_\_

MEDICAL INSURANCE COMPANY'S NAME : \_\_\_\_\_

PROVIDER'S ADDRESS : \_\_\_\_\_

POLICY # : \_\_\_\_\_ EXPIRATION DATE : \_\_\_\_\_

PARENT / GUARDIAN NAME PRINTED : \_\_\_\_\_

PARENT / GUARDIAN SIGNATURE : \_\_\_\_\_ DATE : \_\_\_\_\_

**(OVER)**

**PARENTS' / GUARDIANS' CODE OF ETHICS MUST BE SIGNED**