



Soccer Registration Grades PK-4th

Argyle Youth Sports Association

Deadline: June 20th, 2011



Last Name: _____ First Name: _____ Grade: _____ Sex: _____

Address: _____ City: _____ Zip: _____ Phone: (____) ____ - ____

E-Mail Address (Required): _____

(Print L's as caps and make sure " "s and " _ "s are clear.) PLEASE write clearly or I won't be able to send you information

Years of Soccer Experience: _____ Fee-----\$75.00 Late Fee \$25 Booster club scholarships are available

Monday Night Games: PK-K @ 6:00, 1st/2nd @6:30, 3rd/4th @ 7:00

ALL age Groups will be playing 4v4 Format (only 4 players on a field at one time) at Argyle Intermediate

Shirt Sizes (Circle Shirt Size):	Youth Small	Youth Medium	Youth Large	Adult Small	Adult Medium	Adult Large
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Volunteer: _____ **Coach** _____ **Asst. Coach** _____

Volunteer: _____ **Line Fields/set up** _____ **Referee(or HS sibling\$10/game)** _____

Sponsor a Team: _____ **\$300 for name on back of jersey**

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Registration Deadline !!!! JUNE 20, 2011..

Any special requests here: I will try, but no promises.

Make Checks to: Argyle Youth Sports Association

Send to: Jennifer Goodpaster
3316 Stonecrop Trail
Argyle, Texas 76226
(940) 464-7281 - argylesoccer@verizon.net

FOR MORE INFORMATION, PLEASE VISIT OUR NEW WEBSITE AT **ARGYLESPO RTS.COM**
MEDICAL/EMERGENCY INFORMATION

Who to contact in case of emergency _____ Phone _____

Relationship to Soccer player: _____

Name of Family Physician _____ Phone _____

Insurance Company _____ Allergies: _____

Specific medical problems _____

Waiver of Liability: I, the parent/guardian of the registrant, a minor, agree that the registrant and I will abide by the rules of the Argyle Booster Club. Recognizing the possibility of physical injury associated with soccer and in consideration for the Argyle Booster Club accepting the registrant for its soccer programs and activities, I hereby release, discharge and/or otherwise indemnify the Argyle Booster Club, all Board members, coaches, its affiliates, organizations and sponsors, their employees and associated personnel, including the owners of the facilities used for the programs, against any claims by or on behalf of the registrants as a result of the registrant's participation in the programs.

Consent For Medical Treatment (Minor): I the parent/guardian of the registrant, a minor, hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb, or well being of my dependent.

Parent /Guardian Name: _____ Hm/Cell#: _____

Parent/ Guardian Name: _____ Hm/Cell#: _____