

EOSAY REGISTRATION

Eastern Ohio Soccer Association for Youth PO Box 954 Cambridge, OH 43725
\$45 per child (additional children \$40): Make all checks payable to EOSAY

| | | | |
|---|----------------|------------------|------------------------------------|
| First Name | Middle Initial | Last Name | Sex (circle one) M F |
| Address | | Zip | Telephone |
| Date of Birth | Age as of 7/31 | School Attending | |
| Mother's & Father's Name (or) Legal Guardian's Name | | Cambridge | New Concord (Practice Location) |
| Email address | | | |
| Would you like to coach a team or help coach? | | Yes | No |

CONSENT FOR EMERGENCY MEDICAL TREATMENT

We, the parents of _____, give permission for emergency medical treatment of our child for illness or accident if we cannot first be contacted.

Emergency Phone/Parent or Guardian: Name: _____ Phone: _____

Emergency contact other than parent: Name: _____ Phone: _____

Family Doctor: Name: _____ Phone: _____

Family Dentist: Name: _____ Phone: _____

Does your child have any allergies or requires special medication: Yes No

explain: _____

We hereby agree that the Soccer Association for Youth (SAY), it's members, coaches or officers shall not be held liable for any injury or loss which my child or children may sustain while participating in activities of any kind whether sponsored by or under the supervision of SAY and we agree to indemnify and to hold harmless SAY, it's members, coaches, officers or designates of any kind from any claim whatsoever.

Date _____ Parent/Guardian Signature _____

DO NOT WRITE BELOW ★ EOSAY USE ONLY

U _____ Fee Paid\$ _____ Cash/Check# _____ RecdBy _____ Date _____