



Traverse Bay Area Youth Soccer

Out of Area Registration Form 2010/2011

Out of Area Registration Form

160 Hughes Dr., Traverse City, MI 49686 www.tbays.org

Email: office@tbays.org Phone: 933-8229 Fax: 933-6629

Player Information

Last Name _____ First Name _____ Sex _____

Date of Birth _____ Address _____
Month Day Year Number Street

Phone (____) _____
Area Number City Zip

Email address _____

TEAM SELECTION

TEAM: _____

Registration term:

____ This registration is for the Full Year (Fall 2010 & Spring 2011). I've enclosed \$35 in payment

To Register, I Have Enclosed the Following:

1. This Registration Form (signed and dated) and Medical Care Authorization Form
2. A copy of child's birth certificate
3. Payment in the form of a check made out to TBAYS or Credit Card info below

(Please note that registrations without payment cannot be accepted. Submitting this form without payment WILL NOT secure your place on a team.)

____ VISA or ____ MASTERCARD _____ - _____ - _____ - _____ Exp. Date ____/____/____

Authorized Signature: _____

**** TBAYS Refund policy** – We will refund payments for withdrawals made before the first game of each season. We are sorry but no refunds can be made after those dates.

RELEASE OF LIABILITY

I the below signed parent/guardian/player understand that attending any soccer, rugby or lacrosse program and using the facilities, he/she/I do so at his/her/my own risk. TBAYS and its members, employees, and agents shall not be liable for any damage whatsoever arising from any personal injury or property loss sustained by player, in or about any programs on the premises and I do hereby fully and forever release, discharge and hold harmless TBAYS, all associated facilities and its' members, employees, and agents from any and all action, present or future resulting from or arising out of any person's participation in any programs or use of its' facilities. In addition, I agree to follow the rules of play and conduct set by TBAYS. I understand that failure to do so may result in suspension from participation.

Signature _____ Date _____



AUTHORIZATION TO PROVIDE MEDICAL CARE

TO ANY HOSPITAL OR MEDICAL PROVIDER:

This document constitutes my authorization and consent for you to provide any and all medical and nursing care which you deem necessary or appropriate and in the best interest of my child:

Child's Full Name: _____

Date of Birth(Month/Day/Year): _____ / _____ / _____

I represent to you that I have legal authority to authorize and to consent to such medical care. I further authorize the bearer of this document to execute on my behalf any and all Consent to Treatment forms, including informed consent forms for invasive procedures, which you may require as a condition of treatment.

This authorization is effective this ____ day of _____,20__ and shall remain in effect until I provide you with written notice of revocation.

My child's personal physician is:

Physician's Name: _____

Address: _____

City,State,Zip: _____ Tele: (____) _____

My child's insurance information is:

Insurer/HMO/PPO: _____ Policy #: _____ Group #: _____

Name of Insured: _____

My child's **ALLERGIES** are: _____

My child's **SIGNIFICANT MEDICAL CONDITIONS** and/or **RECENT INJURIES** are: (use back of form if necessary)

Date of my child's last tetanus shot: _____

A copy of this Authorization shall have the same force and effect as the original.

Signature: _____

Print Name: _____ Relationship to child: _____

Address: _____

City,State,Zip: _____

Home Phone:(____) _____ Business Phone:(____) _____

Emergency contact other than parent: Name: _____ Phone:(____) _____

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Signature _____ Date _____