

Lincoln Youth Soccer Association

2012 Spring: Feb 6-29

Mail form & payment to: Lincoln County Parks & Recreation
 400 Hwy 150 East Stanford, KY 40484
Park Office Hours Monday-Friday 9AM-4PM

FOR LEAGUE USE ONLY

<input type="checkbox"/> New	Entered _____
<input type="checkbox"/> Re-registration	

Age Div. _____ Male/Female _____
 Team: _____

Last Name _____	First Name/MI _____
Address _____ City/ Zip _____	
Birthdate _____	Male/ Female _____ Primary Phone _____
School Attending _____	

Father _____	Bus./ Cell Phone _____	Email _____
Mother _____	Bus./ Cell Phone _____	Email _____

FEES and DATES (Circle age group)

Age Group	Birth Dates		Fee*
Under 12	8/1/99	7/31/01	\$65.00
Under 10	8/1/01	7/31/03	\$65.00
Under 8	8/1/03	7/31/05	\$55.00
Under 6	8/1/05	7/31/07	\$55.00

Uniform Sizes

Jersey _____
 YXS-YL
 AS-A2XL

Shorts _____
 YXS-YL
 AS-AXL

If Applicable:

1. Coach Request _____
 2. Player Request _____
***Coaches are responsible for selecting their team based on request.**
***Not all requests will be honored**

CONSENT AND WAIVER

I, the parent/guardian of the registrant, a minor, agree that I and the registrant will abide by the rules of LYSA, its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration for LYSA accepting the registrant for its soccer programs and activities, I covenant and agree to indemnify and hold harmless and do release, quit and forever discharge, LYSA, its Board of Directors, Coaches, Referees and other such volunteers as are connected with LYSA in any capacity, for any and all damages, claims, and/or liability arising out of any and all injury to or caused by my child. With the knowledge and understanding foregoing, this is to certify that my child has permission to play soccer in the LYSA program.

Further, I 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 dependant. I authorize any and all emergency medical treatment deemed necessary by any physician, nurse, or paramedic. A copy of this authorization shall be as effective as the original.

Signature of Parent or Legal Guardian

Date

X _____

OFFICIAL USE ONLY

Registration Fee Paid \$ _____ Cash / Check (# _____) Date _____

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