Boston Youth Soccer League
Registration - 2008

GENERAL INFORMATION: Fill in **ALL** information and submit with your **non-refundable payment of $40 per child.** ($90 max. Per family) Mail to BYSL, P.O. Box 156, Boston NY 14025. **Registration is on a first-come basis, applications submitted after June 16 may not be honored. Late Registrations may not receive uniforms and will not be credited**.

Registration Information

#1 Childs Name ___________________________ Birthdate__/__/__Age as of 6/1/2008
League Experience __yrs. Shirt Size (circle One) YM YL AS AM AL AX Sex M/F
#2 Childs Name ___________________________ Birthdate__/__/__Age as of 6/1/2008
League Experience __yrs. Shirt Size (circle One) YM YL AS AM AL AX Sex M/F
#3 Childs Name ___________________________ Birthdate__/__/__Age as of 6/1/2008
League Experience __yrs. Shirt Size (circle One) YM YL AS AM AL AX Sex M/F
#4 Childs Name ___________________________ Birthdate__/__/__Age as of 6/1/2008
League Experience __yrs. Shirt Size (circle One) YM YL AS AM AL AX Sex M/F

Address ____
Town _________________________ Zip____________ Phone _______________

Parental and Medical Information:
Mother's Name ___________________ Father's Name _______________________
Emergency Number ___________ Relationship to Child_____________________
Special Medical Information ____
Email Address _______________ @ ______________________________________

Consents and Agreements: As the parent/legal guardian of the registrant, a minor, I agree that the registrant and I will abide by the rules of the BYSL. Recognize the possibility of physical injury associated with soccer, and in consideration for the BYSL accepting the registrant for its soccer programs. I hereby release and discharge the BYSL, its affiliated sponsors, their employees and associated personnel, including owners of fields and facilities utilized for the programs, against any claim by or on behalf of the registrant because of the registrant's participation in the programs, and/or being transported to or from, which transportation I hereby authorize. I hereby give my consent for the 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.

I have read the above consents: (signature) _____________________________________

Print Name _________________________ Address ____________________________

Town ______________________________Zip ____________________________

Must be at least 6 but no older than 17 years of age on June 1st. 2008

Prep 6-8 yrs as of 6/1/2008, Junior 9-11 yrs. as of 6/1/2008, Senior 12-15 as of 6/1/2008, Open 16-17 as of 6/1/2008

League Use only
Date ________ Amount $ _________ Cash or Check (Circle One) Check # ______