

# GARRARD CO. YOUTH SOCCER SPRING 2012



*Pattie A. Clay*  
**Regional Medical Center**  


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**GARRARD COUNTY**

<b>BIRTH DATE CHART</b> U-14: 8/1/97 - 7/31/99 U-12: 8/1/99 - 7/31/01 U-10: 8/1/01 - 7/31/03 U-8: 8/1/03 - 7/31/05 U-6: 8/1/05 - 7/31/07 NEW PLAYERS must be inside these dates.
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FIRST  LAST   
 PLAYER NAME

BIRTH DATE M/D/Y  /  / 
 BOY  GIRL

ADDRESS   
 CITY  KY ZIP

HOME PHONE#:  -  -

NEW SPRING PLAYER FEE <small>(did not play fall 11)</small>		RETURNING FALL 11 PLAYER FEE
U-14: \$50.00	<input type="checkbox"/>	U-14: \$30.00
U-12: \$50.00	<input type="checkbox"/>	U-12: \$30.00
U-10: \$45.00	<input type="checkbox"/>	U-10: \$25.00
U-8: \$45.00	<input type="checkbox"/>	U-8: \$25.00
U-6: \$35.00	<input type="checkbox"/>	U-6: \$20.00

EMAIL: \_\_\_\_\_

MOTHER: \_\_\_\_\_ PHONE# \_\_\_\_\_

FATHER: \_\_\_\_\_ PHONE# \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE# \_\_\_\_\_

MEDICAL CONDITION (if any): \_\_\_\_\_

DOCTOR CONTACT: \_\_\_\_\_ PHONE# \_\_\_\_\_

LAST YEAR PLAYED: \_\_\_\_\_ COACH/TEAM: \_\_\_\_\_

SUPPORT YOUR CLUB:  COACH  ASST. COACH  FIELD PREP.

" IMPORTANT" I, the parent/guardian of the registrant, a minor, agree that I and the registrant will abide by the rules of US Youth Soccer, it's affiliated organizations and i sponsors. Recognizing the possibility of physical injury associated with soccer and *in* consideration for the US Youth Soccer! Garrard Youth Soccer accepting the registrant for it's soccer programs and activities, I herby release, discharge and for otherwise indemnify US Youth Soccer/ Garrard Youth Soccer, its affiliated organizations and sponsors, their employees and associated personnel, including the owners of fields and facilities utilized for the programs, against any claim by or on behalf of the registrant as a result of the registrant's participation in the programs and/or being transported to or from the same, which transportation I herby authorize. As a parent or legal guardian of the above-named player, I herby 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, or well-being of my dependent.

SIGN BELOW:

CLUB INFORMATION CONTACTS:  
[WWW.GARRARDSOCCER.COM](http://WWW.GARRARDSOCCER.COM)  
 Kristin Kimble 859-494-3138  
 Find Us on Facebook

Copy of birth cert. is required for all U-8 and older players. Sent with this form or given to the players coach at the first practice.

RETURN FORM TO:  
 GARRARD YOUTH SOCCER  
 PO BOX 60  
 BRYANTSVILLE KY 40410

**FORM MUST BE RETURN BY FEB. 20th; PLAYERS ENTERED AFTER FEB.20th CAN NOT BE GUARANTIED A PLACE ON THE TEAM.**