

**The Little Mav Soccer Club
Registration Form**

The Little Mav Soccer Club has been formed to provide the South Side of Lafayette a fair opportunity for Fall and Spring Travel Soccer. Our focus is player development, and the advancement of soccer in the area. With your help, support, and participation, we hope to transform soccer on the South Side of Lafayette into a competitive Contender with the rest of the State of Indiana.

Player's Name _____ Male ____ Female

Player's Address _____

City: _____ State: _____ Zip: _____

School: _____ Grade: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Mother's Birthday: Month ____ Day ____

Father's Name _____ Mother's Name _____

Father's or Mother's address if different from player _____

Parent Email Address _____

New Player ____ Returning Player ____ Current Jersey Number (If Applicable): _____

Participation Waiver

I hereby give permission for _____ to participate as a member of the Little Mav Soccer Club. I further certify that _____ is in good physical condition as required by the United States Soccer Association. I understand that the Little Mav Soccer Club carries no health or accident insurance. I agree not to hold the Little Mav Soccer Club, its Board, its coaches or referees responsible for injuries occurring during or enroute to or from games and practices. Furthermore, I agree not to hold the Central Indiana Youth Soccer League, Indiana Youth Soccer Association, GIRLS or any of their agents responsible for injuries received in conjunction with participation in this program.

Parent/Guardian's Signature _____ Date: _____

Sponsoring Little Mav Player _____

\$50.00 Registration Fee Due with Form

\$20.00 Late Registration Fee after November 26, 2005

Office Use Only - Do not write below this line

Age Group: _____ Boys Girls Team Assignment:

Birth Date: _____ Name: _____ School:

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Consent for Medical/Surgical Care/Emergency Treatment and Medical Information

I (we) the undersigned parent(s), or legal guardians of _____ hereby give my (our) consent for emergency medical care as 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 (our) dependent.

Signature of Parent/Guardian

Date

Parent/Guardian - **Please Print**

Address:

Home Phone
Phone

Work Phone

Cell

Medical Information

Allergies:

Medications Currently Taking:

Date of Last Tetanus Shot:

Other Pertinent Medical Information

Physician's Name and Phone

Insurance Company

Policy Number _____ Phone Number

**Please Mail Registration and Check to:
LMSC
P O Box 482
Dayton IN 47941**