



WEST END
SOCCER LEAGUE INC.

West End Soccer League, Inc.

www.wesl.us

(Affiliated with E.P.Y.S.A.)

Participant Registration Form

Would you be interested in sponsoring a team?

YES NO

Season: Indoor Spring Fall

CHECK ONE: INTRAMURAL

TRAVEL (Travel Season Fall & Spring Commitment)

CHECK ONE: NEW REGISTRANT

RETURNING REGISTRANT

CHECK APPROPRIATE TITLES: PLAYER

COACH (License, if Available _____)

ASSISTANT COACH

AGE DIVISION: _____ SEX: M F

EMAIL: _____ BIRTH DATE: _____/_____/_____

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____ PHONE NO.: (____) _____ CELL NO.: (____) _____

STATE: _____ ZIP: _____

PLAYER'S / COACH'S SHIRT SIZE (Circle One)

CHILD: SM MED LG

ADULT: SM MED LG EX-LG XX-LG

Does your child have any special or medical needs?

NO

YES _____

Please Help
Donations Needed
Can You Donate?

Y N

\$5.00 \$10.00

Other \$ _____

Payment Ck # _____

Cash Check

Name same on check

If Not _____

Total _____

RELEASE STATEMENT

NOTE:

The Statement must be signed by the parent / guardian for a minor player; adult players, coaches and administrators must sign for themselves.

I, the parent / guardian of the registrant, a minor, or adult registrant of legal age, agree that I and the registrant will abide by the rules of the EPYSA, WESL and its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer, and in consideration for EPYSA and WESL accepting the registrant for its soccer program and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify the EPYSA and WESL, its affiliated organizations and sponsors, their employees and associated personnel, including the owners of fields and facilities utilized by the Programs, against any claim by, or on behalf of, the registrant, as a result of the registrant's participation in the Program, including the transportation to or from the same, which transportation I hereby authorize. Furthermore, I realize that the registration fee paid to participate in the Programs is not refundable beyond June 1st of each soccer season. There will be a \$30.00 Fee for any returned checks.

Signature of Parent / Guardian or Adult Participant

Date

MEDICAL RELEASE:

In case of an emergency, if a family physician cannot be reached, I hereby authorize _____ to be treated by another available physician.

Family Physician: _____ Phone No.: (____) _____

Name of Family Hospitalization Plan: _____ Policy No.: _____

Signature of Parent / Guardian or Adult Participant

Date