2024 WILLARD YOUTH SOCCER CLUB

Players Name: _____ M / F (circle one)

Age as of 4/15/24: _____ Soccer Experience: _____

Custodial Parents/Guardians: _____

Address: _____

Phone: _____ Cell: Y / N Ok to Text? Y / N

Player Shirt Size (circle one): Youth: S M L Adult: S M LG XL

Please list siblings and/or additional requests: _____

_____

REGISTRATION FEE $45 PLAYER OR $90 FAMILY (NO REFUNDS)

PLEASE CONSIDER COACHING AND/OR REFFING. We NEED Coaches and Refs to keep this program going. If coaching or reffing, you will get one (1) child registration free.

Mail/Drop Off Forms & Payments to:
Willard City Hall
P. O. Box 367
631 S. Myrtle
Willard, OH 44890
Checks Payable to Willard Soccer League

For More Information Call:
Rachel Hause: 567-224-7664
Kim Williams: 419-935-1654

Age Groups:
4 - 6, 7 - 9, & 10 - 12

There will be NO children playing in a younger age group. If not enough players are signed up to form the appropriate number of teams, you will be refunded, and there will be no teams for that age group.

Games will start in mid-April depending on the weather. Coaches will contact you once teams have been created to discuss practices and games. **Games will be held on Saturdays.**

DEADLINE FOR REGISTRATION IS MARCH 8TH

Like and follow our Facebook page for updates and information: Willard Youth Soccer Club

2024 WILLARD YOUTH SOCCER CLUB (WYSC)
RECREATIONAL SOCCER SPRING 2024

Player Waiver Form

I hereby grant permission for the above child to participate in the WYSC, including practice and games recognizing that participating will involve competitive physical activity. Voluntarily assume the risk of injury to your child. I hereby waive and release the Willard Youth Soccer Club (WYSC) board members, volunteers, and owners of the fields and facilities utilized, and director of WYSC from claims or liabilities which might occur as a result of participation. I further agree that the child and all parents or guardians of said child will adhere to and abide by the club rules and regulations.

Parents Name: _____

Parents Signature: _____ Date: _____

Emergency medical authorization

I, _____ , the parent or guardian give permission for treatment of a minor illness or injury after a reasonable attempt to contact myself or the Emergency Contact listed below. My preferred Physician and Dentist are listed below, if they are unavailable or are not designated a qualified local Physician or Dentist will be contacted. I further agree to be financially responsible for any and all costs incurred.

List below any facts concerning the child's medical history including allergies, medications and physical impairments or limitations to which the Coach or Physician should be aware. Medical History/Allergies:

_____

_____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Emergency Contact (other than parent/guardian):

Name #1: _____ Phone: _____

Name #2: _____ Phone: _____

Signature: _____ Relationship: _____ Date: _____