Spokane Valley Junior Soccer Association

12505 E. Sprague • PO Box 14732 • Spokane Valley, WA. 99214-0732
Email: spvjsaofc@spvjsa.org • www.spvjsa.org
(509) 922-7910 • Fax (509) 891-1516
Player Registration 20_____/_____

Office Use Only
Age Group_____
Team_____
Coach_____

PLAYER

Last Name | First Name | MI | BIRTH DATE Month Day Year | Boy | Girl

Address | City | State | Zip

Phone Number 5 0 9 - ___ - ____ | Email Address

Parent / Guardian

Address ☐ Check box if address is same as player's address | Street | Cell Phone

City | State | Zip

Employer | Phone

Parent / Guardian

Address ☐ Check box if address is same as player's address | Street | Cell Phone

City | State | Zip

Employer | Phone

Emergency Contact Name | Phone

Doctor's Name | Phone

Player's Medical Restrictions

Parent Participation

We ask for active participation of all parents in our program. Please check area(s) in which you are willing to help

☐ Fund Raising ☐ Team Treasurer ☐ Donation
☐ Team Manager ☐ Referee

AUTHORIZATION TO PARTICIPATE AND CONSENT TO TREATMENT OF A MINOR:

1. AS PARENT/GUARDIAN OF THE ABOVE NAMED PLAYER, I HEREBY GIVE MY APPROVAL TO THE PARTICIPATION IN ANY AND ALL SPOKANE VALLEY JR SOCCER ASSOCIATION (HEREAFTER WRITTEN AS SPVJSA) ACTIVITIES DURING THE CURRENT SEASON. I ASSUME ALL RISKS AND HAZARDS INCIDENTAL TO SUCH PARTICIPATION INCLUDING TRANSPORTATION TO AND FROM THE ACTIVITIES AND I DO HEREBY WAIVE, RELEASE, ABSOLVE, INDEMNIFY AND AGREE TO HOLD HARMLESS THE SPVJSA, THE ORGANIZERS, SPONSORS, SUPERVISORS, PARTICIPANTS, AND PERSONS TRANSPORTING MY CHILD TO OR FROM ACTIVITIES FOR ANY CLAIM ARISING OUT OF AN INJURY TO MY CHILD, EXCEPT TO THE EXTENT AND IN THE AMOUNT COVERED BY ACCIDENT OR LIABILITY INSURANCE.
2. I STATE THAT THE ABOVE NAMED PLAYER HAS NO MEDICAL PROBLEMS, RESTRICTION, OR PROHIBITIONS EXCEPT AS LISTED ABOVE.
3. I, THE UNDERSIGNED PARENT/GUARDIAN OF THE ABOVE NAMED PLAYER, A MINOR, DO HEREBY AUTHORIZE SPVJSA, REPRESENTATIVE AS AGENTS FOR THE UNDERSIGNED, TO CONSENT TO ANY MEDICAL DIAGNOSIS, TREATMENT OR CARE WHICH IS DEEMED ADVISABLE BY ANY PHYSICIAN OR MEDICAL CARE PROVIDER IN THE EXERCISE OF HIS OR HER BEST JUDGMENT.

X _____/ _____ _____
SIGNATURE OF PARENT OR GUARDIAN | DATE | PLAYER SIGNATURE (Required for SELECT & WSYL)

OFFICE USE ONLY

Refunds are subject to an administrative fee and timeline
Birth Certificate Verified: ☐ Yes ☐ No
Payment: ☐ Cash ☐ Check Check No. _____
Payment Received By: _____ Date _____

FEES

Club Affiliation ..... $ _____
Player #____of____ $ _____
Transfer..... $ _____
Tournament..... $ _____
Donation..... $ _____
Add..... $ _____
TOTAL..... $ _____