West Los Angeles Youth Club ❖ P.O. Box 641906 ❖ Los Angeles, California 90064

West Los Angeles Youth Club
Membership Registration 2017-2018

Player: _____ **Team:** _____
LAST FIRST MI

Birthdate: _____ ☐ male ☐ female **Grade (2017-2018 Academic year):** _____
MONTH / DAY / YEAR

MOTHER'S INFORMATION:

Name: _____ **Maiden Name:** _____
LAST FIRST

Address: _____ **Cell Phone:** ( )
STREET APT. NUMBER

E-mail: _____

Home Phone: ( )

_____ **Work Phone:** ( )
CITY STATE ZIP CODE

FATHER'S INFORMATION:

Name: _____
LAST FIRST

Address: _____ **Cell Phone:** ( )
STREET APT. NUMBER

E-mail: _____

Home Phone: ( )

_____ **Work Phone:** ( )
CITY STATE ZIP CODE

Medical Insurance Carrier: _____ **Policy Number:** _____

IN CASE OF MEDICAL EMERGENCY:

If it becomes necessary for my child to have medical, surgical or dental care while participating in any of the West Los Angeles Youth Club activities, I hereby authorize the coaches, assistant coaches, parents, or team members, acting in such capacities or as activity supervisors, as my agents to consent to medical, surgical or dental examination and treatment. In case of such emergency, I hereby authorize treatment and care by any physician and/or at any hospital. In case of emergency for which I cannot be reached, please contact:

Emergency Contact: _____

Relationship: _____ **Telephone:** ( )

I, the undersigned parent or guardian of the registrant, hereby state and confirm that all information provided above is correct. I have read all of the foregoing and am fully aware of the legal consequences of signing this instrument.

_____ _____ _____
PARENT/GUARDIAN SIGNATURE PRINT NAME DATE