



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

West Los Angeles Youth Club Membership Registration 2015-2016

Player: _____ Team: _____
LAST FIRST MI

Birthdate: _____ male female Grade (2015-2016 Academic year): _____
MONTH / DAY / YEAR

MOTHER'S INFORMATION: _____

Name: _____ Maiden Name: _____
LAST FIRST

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

_____ E-mail: _____

_____ Home Phone: _____
CITY STATE ZIP CODE ()

Work Phone: _____
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FATHER'S INFORMATION: _____

Name: _____
LAST FIRST

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

_____ E-mail: _____

_____ Home Phone: _____
CITY STATE ZIP CODE ()

Work Phone: _____
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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: _____
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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