



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

### West Los Angeles Youth Club Membership Registration 2009-2010

Player: \_\_\_\_\_ Team: \_\_\_\_\_  
LAST FIRST MI

Birthdate: \_\_\_\_\_  male  female Grade (2009-2010 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