



## NTSC Challenge / Classic Registration Form

Mail completed form back to:  
 NTSC  
 PO Box 1529  
 King, NC 27021

NTSC Soccer Board of Directors meetings are held the 2nd Tuesday of every month at 7 p.m. at the building at Recreation Acres. **All parents, coaches and others are encouraged to attend.**

www.ntsoccerclub.com

<b>Player Info</b>	Birth Certificate Name Only _____ Nickname _____ Mailing Address _____ Home Phone _____ Cell Phone _____ Date of Birth _____ <input type="checkbox"/> Female <input type="checkbox"/> Male																	
<b>Contact Information</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Shirt Size</td> <td colspan="3" style="text-align: center;">Youth Sizes</td> <td colspan="4" style="text-align: center;">Adult Sizes</td> </tr> <tr> <td></td> <td style="text-align: center;">S</td> <td style="text-align: center;">M</td> <td style="text-align: center;">L</td> <td style="text-align: center;">S</td> <td style="text-align: center;">M</td> <td style="text-align: center;">L</td> <td style="text-align: center;">XL</td> </tr> </table> Fathers Name / Email _____ Cell Phone _____ Mothers Name / Email _____ Cell Phone _____ Any Medical Problems or prohibition player has _____ Person to notify in an emergency _____ Phone _____ Doctor to notify in an emergency _____ Phone _____		Shirt Size	Youth Sizes			Adult Sizes					S	M	L	S	M	L	XL
Shirt Size	Youth Sizes			Adult Sizes														
	S	M	L	S	M	L	XL											
<b>Tryout Liability Release</b>	I, as legal parent or guardian, hereby give permission for _____ to participate in a Northern Triad Soccer Club tryout for eligibility on a Classic/Challenge soccer team. I hereby release and forever discharge NTSC, the Classic/Challenge League and its coaches, agents and the owners of any fields used during this tryout from all liability for any personal; injury or illness, damage or loss incurred while participating in the tryout process. In the event I cannot be reached in an emergency, I hereby grant permission to the NTSC Executive Board members or designated representative, to secure treatment for the above named person.  Signed: _____ Date: _____ Relationship: _____ Player Name: _____ Player Date of Birth: _____ Phone Number: _____																	
<b>Release</b>	I, the parent/guardian of the registrant, a minor, agree that I and the registrant will abide by the rules of <b>Northern Triad Soccer Club</b> , its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration by the USYSA and NCYSA, accepting the registrant for its soccer programs and activities (the "Programs"). I hereby release, discharge and/or otherwise indemnify the USYSA, its affiliated organizations and sponsors, their employees and associated personnel, including the owners of the fields and facilities utilized for the Programs, against any claim by or on behalf of the registrant as a result of the registrant's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize.  Print Name _____ Signature _____ Parent/Legal Guardian _____ Date _____	<b>Medical Consent</b>																
<b>Parental Support</b>	We ask for participation of all parents in our program. Check area(s) in which you would be willing to help. <input type="checkbox"/> Coach <input type="checkbox"/> Club Sponsor <input type="checkbox"/> Publicity <input type="checkbox"/> Assistant Coach <input type="checkbox"/> Fund Raising <input type="checkbox"/> Referee <input type="checkbox"/> Team Manager <input type="checkbox"/> Field Preparation <input type="checkbox"/> Clerical <input type="checkbox"/> Team Parent <input type="checkbox"/> Special Projects <input type="checkbox"/> Newsletter <input type="checkbox"/> Age Group Cord. <input type="checkbox"/> Board Member <input type="checkbox"/> Donor Other: _____	<b>Club Use Only</b>																
		As the parent or legal guardian of the above named player, I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of my dependent.  Signature of Parent or Guardian _____ X _____ Address _____ City _____ State _____ Zip _____ Home Phone _____																
		<input type="checkbox"/> Fees Paid <input type="checkbox"/> Cash <input type="checkbox"/> Money Order <input type="checkbox"/> Check Fee Amount \$ _____ Check # _____ BOD Initial _____ Date Rec'd: _____ Age Group _____ Team _____																