

2009-2010 Olympic Development Program
1993-95 Age Groups

(EVERY PARTICIPATE MUST COMPLETE THIS FORM AND MAKE SURE IT IS NOTARIZED)

NAME _____
(Last Name) (First Name) (Middle Initial)

Player Pass # _____ Birth date ____/____/____

Address _____ City _____ Zip _____

Phone (____) _____ - _____ USA Citizen: Yes _____ No _____

Email _____

Confirmation letters will be sent via email. Please print clearly. Notification for the trials should be sent out shortly after the February 4th deadline. Contact the FYSA office or mstrickler@fysa.com if you have not received yours.

Please put your district, club/team and league code from your player pass here.

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District Club Team League

Emergency Contact _____ Relationship to player _____

Home Phone (____) _____ - _____ Work Phone (____) _____ - _____

Gender: Boy _____ Girl _____ Age Group: _____ 93 _____ 94 _____ 95 Check if GK _____
(Goalkeeper)

Feb. 20-21(RegC) _____ Feb. 27-28(RegA) _____ March 6-7(Palm Bay) _____

*The date and site of the trials can be found at www.fysa.com under ODP.

ENTRY FEE: \$65 (NON-REFUNDABLE) CHECK OR CREDIT CARD

Payable to: FYSA Address: Florida Youth Soccer Association
Attn: ODP
7201 Lake Ellenor Dr Suite 200
Orlando, FL 32809

Credit Card Payments: V/MC/D/AMEX Acct. # _____ Exp. Date _____ 3 Digit Pin Code _____

Name on Credit Card _____

Authorizing Signature _____

All ODP Applications must be notarized and submitted with the proper fee with a postmark deadline of February 4th, 2010. Applications received after February 4th will be accepted but an additional late fee of \$25(\$90 total non-refundable) should be attached and the application and fee must be in the state office no later than the Tuesday before the Saturday trial. No Hand-Delivered or Faxed Applications will be accepted.

Consent for Medical Treatment

As the parent or Legal Guardian of, _____
I hereby give my consent for emergency medical care 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 and well being of my dependent. (Attach any information on a separate sheet that you feel necessary-allergies, medical problems, etc.)

Signature of Parent Guardian _____

Date signed _____ Notary Public State of _____

Commission # _____ Expiration _____

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