

**ROSWELL YOUTH FOOTBALL LEAGUE (RYFL)  
REGISTRATION FORM - FLAG DIVISION**

**PLEASE PRINT:**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE AS OF SEPTEMBER 1, \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

BROTHER/SISTER OPTION \_\_\_\_\_

**CONTACT INFORMATION**

MOTHER'S NAME: \_\_\_\_\_ E-Mail: \_\_\_\_\_

MOTHER'S PHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ E-Mail: \_\_\_\_\_

FATHER'S PHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

GUARDIAN'S NAME: \_\_\_\_\_ E-Mail: \_\_\_\_\_

GUARDIAN'S PHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

EMERGENCY CONTACT NAME (if other than parent or guardian) \_\_\_\_\_

EMERGENCY CONTACT PHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_

I would be interested in coaching a flag team: \_\_\_\_\_ Head Coach \_\_\_\_\_ Asst Coach

No refunds will be given after game shirt has been ordered.

*Returned checks will be subject to a \$30.00 service fee.*

\_\_\_\_\_  
*Signature of Parent/Guardian*

**Make checks payable to RYFL**

*Revised 07/11/2013*

<b><u>FOR RYFL USE ONLY</u></b>		
Amount Paid \$ _____	Check # _____	Cash _____
Receipt # _____	_____ <i>(Signature of Board Member)</i>	

**MEDICAL AUTHORIZATION PERMISSION FORM**

\_\_\_\_\_  
**PLAYER NAME**

\_\_\_\_\_  
**DATE**

**IN THE EVENT THE NEED ARISES TO PROVIDE UNFORESEEN OR EMERGENCY MEDICAL TREATMENT TO MY SON/DAUGHTER, I UNDERSTAND THAT EVERY EFFORT WILL BE MADE TO CONTACT ME FOR MY PERMISSION; HOWEVER, IN THE EVENT THAT I CANNOT BE CONTACTED, I HEREBY AUTHORIZE THE COACHING STAFF OF THE ROSWELL YOUTH FOOTBALL LEAGUE TO ACT ON MY BEHALF AND GIVE THEM THIS MEDICAL ASSIGNMENT RELEASE FOR NECESSARY MEDICAL TREATMENT.**

*INSURANCE COMPANY:* \_\_\_\_\_

*POLICY NUMBER/NAME:* \_\_\_\_\_

I should be able to be reached by Telephone at on of the following numbers:

Area Code \_\_\_\_\_ / \_\_\_\_\_

Area Code \_\_\_\_\_ / \_\_\_\_\_

Area Code \_\_\_\_\_ / \_\_\_\_\_

Area Code \_\_\_\_\_ / \_\_\_\_\_

**MY SON/DAUGHTER HAS NO KNOWN ALLERGIES TO ANY KNOWN MEDICATIONS**

**MY SON/DAUGHTER IS ALLERGIC TO THE FOLLOWING MEDICATIONS OR OTHER NATURAL SUBSTANCES:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**MY SON/DAUGHTER IS CURRENTLY TAKING THE FOLLOWING MEDICATIONS:  
(PRESCRIBED OR OVER-THE-COUNTER)**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

\_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**

