



# NEW HAMPSHIRE SOCCER ASSOCIATION OLYMPIC DEVELOPMENT PROGRAM REGISTRATION FORM



Registration Fee \$30.00  
Please make checks payable to NHSA ODP

Tryout # \_\_\_\_\_

Check # \_\_\_\_\_ Amount \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ M/F \_\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Fathers Name \_\_\_\_\_ Phone \_\_\_\_ - \_\_\_\_\_

Mothers Name \_\_\_\_\_ Phone \_\_\_\_ - \_\_\_\_\_

E-Mail Parent \_\_\_\_\_ E-Mail Child \_\_\_\_\_

Club Soccer Team \_\_\_\_\_ Coach \_\_\_\_\_

School Soccer Team \_\_\_\_\_ Coach \_\_\_\_\_

Prior ODP Experience \_\_\_\_\_

Uniform Shirt Size \_\_\_\_\_ Short Size \_\_\_\_\_ Jacket Size \_\_\_\_\_

School \_\_\_\_\_ Year of Graduation \_\_\_\_\_ GPA \_\_\_\_\_

Person to Notify In Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

Doctor to Notify In Case Of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

Medical Plan \_\_\_\_\_ Plan # \_\_\_\_\_

**Consent for Medical Treatment**

As a parent or legal guardian of the above named player, I hereby give my 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 \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_