### GPLA SPORTS REGISTRATION FORM

**SPORT**  
Girl’s Soccer

**DIVISION**  
Little Kickers (GPLA)

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**PLAYER**

- **Last Name**
- **First Name**
- **Birth date** / /  
- **Age**
- **Grade**
- **Height**
- **Weight**
- **School**

**Are you a returning player?**  
Yes  No  
If yes, **Team**

**Do you have a sister playing in this same age division?**  
Yes  No  
If yes, **Name**  **Age**

**Same team privileges will only apply to siblings**

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**GENERAL**

- **Address**
- **City**
- **Zip Code**
- **Parent/Guardian**
- **Home Phone** ( )
- **Work Phone** ( )
- **Cell Phone** ( )
- **Email**
- **Emergency Contact Name**
- **Work Phone** ( )
- **Cell Phone** ( )
- **Home** ( )

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**PARENT CONSENT FORM**

**Parent Consent:** I give permission for my child, whose name is listed below, to participate in the __________ Soccer ______ GPLA Program. I authorize the City to make, procure or use photographs, film, tapes or other likenesses or Minor’s physical image and/or voice as may be needed for use with program’s publicity material. I agree to hold harmless the City of Los Angeles, Department of Recreation and Parks. I understand that the City of Los Angeles carries no insurance. I also understand the Recreation Director reserves the right to dismiss a child for any conduct detrimental to the program.

**AUTHORIZATION OF CONSENT TO TREATMENT OF A MINOR AT AN AUTHORIZED HOSPITAL IN CASE OF EMERGENCY, ILLNESS OR ACCIDENT:** I (We) the undersigned, parent(s) of the Minor, whose name is listed above, do hereby authorize Leland Recreation Center as agent for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care which is deemed advisable, and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provision of the Medical Practice Act on the medical staff of a licensed hospital whether such diagnosis or treatment is rendered at the office of said physician or at the said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but it is given to provide authority and power on the part of aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

**Signature**

**Date**

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**PARENTS’ OATH TO KIDS**

I promise to demonstrate good sportsmanship by being a positive role model and encouraging you to play and have fun while supporting you and your team in both victory and defeat.

**Signature**

**Date**

**Signature**

**Date**

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**RR NUMBER**

**AMOUNT**

**RECEIVED BY (Initial)**

**AGE VERIFIED (Initial)**

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