



**PLAYER INFORMATION AND MEDICAL RELEASE**

Player's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

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

T-shirt Size \_\_\_\_\_ U.S. Citizen: Yes \_\_\_\_\_ No \_\_\_\_\_ H.S. Attending \_\_\_\_\_

e-mail address: \_\_\_\_\_ Expected H.S. Graduation Yr: \_\_\_\_\_

**EMERGENCY INFORMATION**

Father's Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

**In an emergency when parents cannot be reached, please contact:**

Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Allergies \_\_\_\_\_

Other medical conditions \_\_\_\_\_

Injuries in the past 12 months \_\_\_\_\_

Player's Physician \_\_\_\_\_ Office No. (\_\_\_\_) \_\_\_\_\_

Medical and/or Hospital Insurance Company \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

***PLEASE COPY BOTH SIDES OF YOUR MEDICAL INSURANCE CARD & ATTACH TO THIS FORM***

**PARENT'S APPROVAL AND MEDICAL RELEASE**

Recognizing the possibility of physical injury associated with soccer and in consideration for the US Soccer/USYS and its affiliates accepting the registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify the US Soccer/USYS, its affiliates, organizations and sponsors, their employees and associated personnel, including the owners of 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.

My son/daughter has received a physical examination by a physician and has been found physically capable of participating in the Programs. I hereby give my consent to have an athletic trainer and/or doctor of medicine or dentistry provide my son/daughter with medical assistance and/or treatment and agree to be responsible financially for the reasonable cost of such assistance and/or treatment.

\_\_\_\_\_  
(Parent's Printed Name)

\_\_\_\_\_  
(Parent's Signature)

\_\_\_\_\_  
(Date)