Print Form

Alabama Youth Soccer

A Division of ASA

PLAYER INFORMATION AND MEDICAL RELEASE FORM

Player's Name _____ Date of Birth _____

Address _____ City _____ State_____ Zip_____

U.S. Citizen: Yes_____ No_____ H.S. Attending_____

e-mail: _____ Expected H.S. Graduation Yr: _____

EMERGENCY INFORMATION

Father's Name_____ Home Phone (____)_____ Work Phone (____)_____

Cell Phone (___)_____ email:_____

Mother's Name _____ Home Phone (____)_____ Work Phone (____)_____

Cell Phone (___)_____ email:_____

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

Name _____Home Phone (____)_____Cell (___)_____

Name _____Home Phone (____)_____Cell(___)_____

Allergies _____

Other medical conditions _____

Injuries in the past 12 months_____

Player's Physician_____ Home Phone (____)_____Work Phone (____)_____

Medical and/or Hospital Insurance Company _____ Phone (____)_____

Policy Holder _____ Policy # _____Group # _____

PLEASE COPY <u>BOTH</u> 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 USSF/USYSA and its affiliates accepting the registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify the USSF/USYSA, its affiliated 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.

_____ _____ _____

(Parents Printed name) (Parents Signature) (Date)

Sworn to and subscribed before me this _____ day of _____, 200__

_____ My commission expires _____

Notary