US YOUTH SOCCER ASSOCIATION, INC.

REGION II OLYMPIC DEVELOPMENT PROGRAM

PLAYER INFORMATION AND MEDICAL RELEASE FORM

NAME: ____ BIRTHDATE: ____/____/_______

ADDRESS: ______________________________ CITY: __________________ STATE: ______ ZIP: ________

EMERGENCY INFORMATION

FATHER'S NAME: ____

HOME PHONE: (_____)__________ WORK PHONE: (_____)_________ CELL PHONE: (_____)__________

MOTHER'S NAME: ____

HOME PHONE: (_____)__________ WORK PHONE: (_____)_________ CELL PHONE: (_____)__________

In case of emergency, when parents cannot be reached, please contact:

NAME: ___________________________ PHONE: HM (_____)__________ WK (_____)__________

NAME: ___________________________ PHONE: HM (_____)__________ WK (_____)__________

Allergies: ____

Other medical conditions: ____

____

Physician's Name: _________________________ PHONE: HM (_____)__________ OFC (_____)__________

Medical and/or Hospital Insurance Company: _____________________________ PHONE: (_____)__________

Policy Holder: _______________________ Policy Number: ___________________ Group Number: __________

PLEASE COPY BOTH SIDES OF YOUR MEDICAL INSURANCE CARD AND ATTACH TO THIS FORM!

Parent's Approval and Medical Release:

Recognizing the possibility of physical injury associated with soccer and/or sudden illness at an event, and in consideration for the USSF/US Youth Soccer and its affiliates accepting the registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify the USSF/US Youth Soccer, its affiliated organizations and sponsors, their employees and associated personnel, including the owner 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 each assistance and/or treatment.

____ _____________________

Signature of Parent/Guardian *Date*

Subscribed and sworn to before me this ___________ *day of* _________, *20*___.

____

Notary Public

(Raised seal or original Notary stamp is mandatory)

My commission expires ___________________