

McPherson Strikers Player Information/Medical Release Form 2010-2011

UNITED STATES YOUTH SOCCER ASSOCIATION, INC.

A Division of United States Soccer Federation



Kansas State Youth Soccer Association/ McPherson Strikers



Player's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_
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 an emergency when parents can not be reached, please contact:

Name \_\_\_\_\_ Home Phone \_\_\_\_\_
Work Phone \_\_\_\_\_
Cell Phone \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_
Work Phone \_\_\_\_\_
Cell Phone \_\_\_\_\_

Allergies \_\_\_\_\_

Other Medical Conditions \_\_\_\_\_

Player's Physician \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_ Work Phone \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Number \_\_\_\_\_

PARENTS APPROVAL AND MEDICAL RELEASE

Recognizing the possibility of physical injury associated with soccer and in consideration for the USSF/USYSA and 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 the 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 for such assistance and/or treatment.

\_\_\_\_\_  
Signature of Parent/Guardian Date

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_



\_\_\_\_\_  
Notary Public

(Affix Seal or Original Stamp)

My Commision Expires \_\_\_\_\_