PARENT/GUARDIAN CONSENT AND PLAYER MEDICAL RELEASE FORM

Player's Name: _____ Date of Birth: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

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: _____

Player's Physician: _____ Home Phone: _____ Work Phone: _____

Medical and/or Hospital Insurance Company: _____ Phone: _____

Policy Holder: _____ Policy #: _____ Group #: _____

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

PARENT/GUARDIAN CONSENT AND MEDICAL RELEASE

Recognizing the possibility of injury or illness, and in consideration for US Youth Soccer and members of US Youth Soccer accepting my son/daughter as a player in the soccer programs and activities of US Youth Soccer and its members (the "Programs"), I consent to my son/daughter participating in the Programs. Further, I hereby release, discharge, and otherwise indemnify US Youth Soccer, its member organizations and sponsors, their employees, associated personnel, and volunteers, including the owner of fields and facilities utilized for the Programs, against any claim by or on behalf of my player son/daughter as a result of my son's/daughter's participation in the Programs and/or being transported to or from the Programs. I hereby authorize the transportation of my son/daughter to or from the Programs.

My player son/daughter has received a physical examination by a licensed medical doctor and has been found physically capable of participating in the sport of soccer. I have provided written notice, which is submitted in conjunction with this release and attached hereto, setting forth any specific issue, condition, or ailment, in addition to what is specified above, that my child has or that may impact my child's participation in the Programs. I give my consent to have an athletic trainer and/or licensed medical doctor or dentist provide my son/daughter with medical assistance and/or treatment and agree to be financially responsible for the reasonable cost of any such assistance and/or treatment.

_____ _____

Signature of Parent/Guardian Date

US YOUTH SOCCER Region III

OLYMPIC DEVELOPMENT PROGRAM
MEDICAL HISTORY QUESTIONNAIRE

LAST NAME_____ FIRST NAME_____ MIDDLE INITIAL_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

DATE OF BIRTH_____-_____-_____ SEX ____✔__M ____✔__F

EMERGENCY CONTACT_____ HM PH (_____)_____ WK PH (_____)_____

PLEASE Check EITHER **"YES"** OR **"NO"** TO ALL QUESTIONS AND PROVIDE ADDITIONAL DETAILS WHERE REQUESTED. YOU MAY PUT DETAILS ON THE BACK OF THIS FORM IF NEEDED. ALL INFORMATION IS CONFIDENTIAL.

1) ARE YOU ALLERGIC TO ANY MEDICATION (ASPIRIN, PENICILLIN, SULFA, ETC)? **YES NO** (LIST)_____
2) DO YOU TAKE ANY PRESCRIBED MEDICATION ON A PERMANENT BASIS OR SEMI-PERMANENT BASIS (STEROIDS, BIRTH CONTOL PILLS, ANIT-INFLAMMATORIES, ANTIBIOTICS, ETC)? **YES NO** (LIST & GIVE REASON)_____
3) HAVE YOU EVER HAD ANY EPILEPTIC SIEZURE? **YES NO**
4) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE EPILEPSY? **YES NO** (LIST MEDICATION)_____
5) HAVE YOU EVER BEEN TREATED FOR DIABETES? **YES NO**
6) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU WERE ANEMIC? **YES NO** WHEN?_____
7) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE SICKLE CELL ANEMIA? **YES NO**
8) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE SICKLE CELL TRAIT? **YES NO** _____
9) DO YOU HAVE OR HAVE YOU EVER HAD HIGH BLOOD PRESSURE? **YES NO** (LIST MEDICATION)_____
10) DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING DISEASES?
HEART DISEASE (HEART MURMER, RHEUMATIC FEVER) **YES NO** (GIVE DATE)_____
LUNG DISEASE (PNEUMONIA) **YES NO** (GIVE DATE)_____
KIDNEY DISEASE (INFECTIOUS) **YES NO** (GIVE DATE)_____
LIVER DISEASE (MONONUCLEOSIS, HEPATITIS) **YES NO** (GIVE DATE)_____
11) DO YOU HAVE OR HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE ASTHMA? **YES NO** (LIST MEDICATION)_____
12) DO YOU HAVE OR HAVE YOU EVER HAD A HERNIA OR "RUPTURE"? **YES NO** HAS IT BEEN REPAIRED?_____DATE_____
13) HAVE YOU EVER BEEN "KNOCKED OUT"(UNCONSCIOUS) IN THE PAST 3 YEARS? **YES NO** (LIST DATES)_____
14) HAVE YOU EVER HAD A CONCUSSION OR OTHER HEAD INJURY IN THE PAST 3 YEARS? **YES NO** (LIST DATES)_____
15) HAVE YOU STAYED OVERNIGHT IN THE HOSPITAL DUE TO A HEAD INJURY? **YES NO** (LIST DATES)_____
16) HAVE YOU EVER HAD A NECK INJURY INVOLVING BONES, NERVES, OR DISKS THAT DISABLED YOU FOR A WEEK OR LONGER?
YES NO TYPE OF INJURY_____DATES_____
17) DO YOU WEAR GLASSES OR CONTACTS DURING COMPETITION? **YES NO**
18) DO YOU WEAR ANY OF THE FOLLOWING DENTAL APPLIANCES? **YES NO** (CIRCLE THOSE WHICH APPLY) PERMANENT BRIDGE, BRACES, REMOVABLE RETAINER, PERMANENT RETAINER, REMOVABLE PARTIAL PLATE, FULL PLATE, PERMANENT CROWN OR JACKET?
19) HAVE YOU HAD A BROKEN BONE OR FRACTURE IN THE PAST 2 YEARS? **YES NO** _____RIGHT OR_____LEFT
WHAT BONE(S)_____DATES_____
20) HAVE YOU EVER HAD A SHOULDER INJURY IN THE PAST 2 YEARS THAT DISABLED YOU FOR A WEEK OR LONGER? (DISLOCATION, SEPARATION, ETC) **YES NO** _____RIGHT OR_____LEFT TYPE OF INJURY_____DATE_____
21) HAVE YOU EVER HAD SHOULDER SURGERY? **YES NO** _____RIGHT OR _____LEFT DATE_____
WHAT WAS DONE AND WHY?_____
22) HAVE YOU EVER INJURED YOUR BACK? **YES NO** TYPE OF INJURY_____DATE_____
23) DO YOU HAVE BACK PAIN? **YES NO** (CIRCLE THOSE THAT APPLY) SELDOM, OCCASIONALY, FREQUENTLY, WITH VIGOROUS EXERCISE, WITH HEAVY LIFTING
24) HAVE YOU INJURED YOUR KNEE IN THE PAST 2 YEARS? **YES NO** _____RIGHT OR _____LEFT DATE_____
25) HAVE YOU BEEN TOLD BY A DOCTOR OR ATHLETIC TRAINER THAT YOU INJURED THE CARTILAGE IN YOUR KNEE? **YES NO**
_____RIGHT OR _____LEFT DATE_____
26) HAVE YOU BEEN TOLD BY A DOCTOR OR ATHLETIC TRAINER THAT YOU INJURED THE LIGAMENTS IN YOUR KNEE? **YES NO**
_____RIGHT OR _____LEFT DATE_____
27) HAVE YOU HAD KNEE SURGERY? **YES NO** _____RIGHT OR _____LEFT WHAT WAS DONE?_____DATE_____
28) HAVE YOU HAD A SEVERE ANKLE SPRAIN IN THE PAST 2 YEARS? **YES NO** _____RIGHT OR _____LEFT DATE_____
29) DO YOU HAVE A PIN, SCREW, OR PLATE IN YOUR BODY? **YES NO** LOCATED WHERE_____DATE_____
30) DO YOU HAVE OTHER CONDITIONS THAT WE SHOULD BE AWARE OF (I.E. ULCERS, PREGNANCY, FOOD OR INSECT ALLERGIES, TENDINITIS, ETC)? **YES NO** (SPECIFY & GIVE DETAILS)_____
31) DATE OF LAST IMMUNIZATION: _____TETANUS _____POLIO _____MUMPS _____RUBELLA _____MEASLES

THE QUESTIONS ON THIS FORM HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.

PARENT/GUARDIAN SIGNATURE_____ **DATE**_____

ATHLETE'S SIGNATURE_____ **DATE**_____