UNITED STATES YOUTH SOCCER ASSOCIATION, INC.

A Division of United States Soccer Federation

Southern Lehigh Soccer League

PLAYER INFORMATION AND MEDICAL RELEASE FORM

Boys:______ Girls:_______ Age Group: U_____

Player's Name____ Date of Birth__________________

Address________________________________ City________________________ State______ Zip_________

Email Address____

EMERGENCY INFORMATION

Father's Name____________________ Daytime # (______)_____________ Evening # (______)_______________

Cell # (______)______________________ Email____

Mother's Name____________________ Daytime # (______)_____________ Evening # (______)_______________

Cell # (______)______________________ Email____

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

Name____________________ Daytime # (______)_______________ Evening # (______)_________________

Cell # (______)______________________ Email____

Name____________________ Daytime # (______)_______________ Evening # (______)_________________

Cell # (______)______________________ Email____

Allergies____

Other medical conditions____

Player's Physician ___________________ Daytime # (______)_______________ Evening # (______)__________

Medical and/or Hospital Insurance Company_____________________________ Phone (______)_______________

Policy Holder__________________________________ Policy Number_______________________________

PARENT'S APPROVAL AND MEDICAL RELEASE

Recognizing the possibility of physical injury associated with soccer and in consideration for the USSF/USYSA and it's 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.

______________________________ ______________

Signature of Parent/Guardian Date

Subscribed and sworn to before me this ______ day of _______________________________, 200____

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Notary Public

Notary Public My commission expires ____________________

(Raised seal or original stamp