



United States Youth Soccer Association, Inc.  
A division of United States Soccer Federation



**KANSAS STATE YOUTH SOCCER ASSOCIATION**

Player Information and Medical Release Form

Player's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

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 can't 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 Number \_\_\_\_\_

**PARENT'S APPROVAL AND MEDICAL RELEASE**

Recognizing the possibility of physical injury associated with soccer and in consideration for the USSF/US Youth Soccer and 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 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 of 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 commission expires \_\_\_\_\_