

Massachusetts Youth Soccer Association



Fall River Youth Soccer TOPSoccer Program

Participant Information

Athlete Information

Name: _____ Date of Birth _____

Address: _____

City: _____ State: ____ Zip: _____ Phone # _____

Sex: M _____ F _____

Parent/Guardian Information

Parent(s)/Guardian(s): _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone # _____

Office Phone # _____ Cellular Phone # _____

Emergency Information

Person to contact in case of emergency: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone # _____

Office Phone # _____ Cellular Phone # _____

Health Information

Circle One Comments

Down Syndrome Yes No _____

Atlantoaxial instability evaluation by x-ray Yes R _____
(Circle Yes for Positive, R for Negative)

History of: Circle One Comments

Atlantoaxial instability Yes No _____

Diabetes Yes No _____

Heart problems/blood pressure elevation Yes No _____

Seizures Yes No _____

Vision problems and/or less than
20/20 vision in one or both eyes Yes No _____

Hearing aid/hearing problem Yes No _____

Motor impairment requiring special equipment Yes No _____

Type(s) of special equipment/aid used _____
Bleeding problem Yes No _____
Head injury/history of concussion Yes No _____
Fainting/dizzy spells Yes No _____
Heat illness or cold injury Yes No _____
Hernia or absence of one testicle Yes No _____
Recent contagious disease(s) or hepatitis Yes No _____
Explain if Yes _____
Kidney problem or loss of function in one Yes No _____
Urinary problem/incontinence Yes No _____
Pregnancy Yes No _____
Bone or joint problems Yes No _____
Contact lens/glasses Yes No _____
Dentures/false teeth Yes No _____
Emotional problems Yes No _____
Special dietary needs Yes No _____
Other Yes No _____

1. Medical condition(s) about which the coaching staff should be aware:

2. Behavioral information that may be of help to the coaching staff:

Special Medication(s)

Medication Name Amount Time(s) Usually Taken Date Prescribed

Known allergies/adverse reactions to medication(s)/food(s): _____

Doctor(s)

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

Signature

Signature of person completing this Participant Information form
(Parent, guardian, adult athlete)

_____ **Date:** _____



Fall River Youth Soccer TOPSoccer Program

ATHLETE'S APPLICATION/AGREEMENT TO PARTICIPATE

I, _____, wish to participate in youth soccer, and more particularly in the Fall River Youth Soccer TOPSoccer Program. In connection with my participation, I acknowledge the risk of possible physical harm to me as a result of my participation and that the risk of harm may be increased because of my (name(s) of disability(ies) _____ and for which I have received or am receiving medical attention.

While there is no immediate danger to me, I am told that strenuous, collision type activities, such as soccer, could render me more susceptible to future problems due to my disability(ies) than might normally be expected. I have discussed this situation with my parent(s)/guardian(s) and we understand the potential danger of participating in soccer.

Notwithstanding that my participation in youth soccer may constitute more risk to me than it does to other athletes, I nevertheless wish to participate in youth soccer. In making this decision, I am aware of the value of participating in youth sports programs in my life, and choose to participate in order to take full advantage of those values. In weighing the risk to myself of potential injury now and in the future, I wish to exonerate and save harmless the Fall River Youth Soccer TOPSoccer Program, its sponsoring club/association, and the Massachusetts Youth Soccer Association and the agents, servants and employees of those organizations, from any liability as a result of an injury or death relating to my disability(ies) and not to any injury that may occur in the future which is unrelated to my disability(ies). I execute this agreement freely, fully intending to be bound by same.

Participant Name Date of Birth

Participant Signature

Address

Parent/Guardian Signature Date

Massachusetts Youth Soccer Association



Fall River Youth Soccer TOPSoccer

Program

PARENTAL CONSENT FOR TOPSOCCER PARTICIPATION

I am the parent/legal guardian of _____ and on whose behalf I have submitted the attached Athletes Application/Agreement to Participate in the Fall River Youth TOPSoccer Program

I hereby declare and warrant that to the best of my knowledge and belief that he/she is both physically and mentally able to participate in TOPSoccer. With my approval, a licensed physician has certified that, based on an independent medical examination, there is no medical evidence that would preclude his/her participation in TOPSoccer. I also understand that if he/she has been diagnosed to have Down Syndrome, a radiological examination for the purpose of determining the presence or absence of atlantoaxial instability is required for his/her participation in TOPSoccer.

I further understand that my presence or the presence of my spouse or other legal guardian is required at all Fall River Youth Soccer TOPSoccer and Massachusetts Youth Soccer Association (Mass Youth Soccer) TOPSoccer Program events, including but not limited to practices, games, festivals. etc. in which he/she participates. I clearly understand that the reason for the required presence of a parent or guardian for TOPSoccer activities is based in part on issues surrounding emergency care should it be needed.

In permitting my son/daughter to participate in the Fall River Youth Soccer TOPSoccer Program, I specifically grant my permission for TOPSoccer to use his/her likeness, name, voice, and/or words in television, radio, film, newspaper, magazine, and/or other media for the purpose of informational outreach for TOPSoccer and/or seeking funds and other types of support for TOPSoccer.

As the parent/legal guardian of _____. I have read and understand fully each of the above provisions. Through my signature on this consent form, I acknowledge and agree with each of the above provisions on my own behalf and that of my participating child. I also recognize the potential risk(s) that are involved with my child's participation in TOPSoccer and agree to hold harmless the TOPSoccer coaches, volunteers, and others involved in administering this program should harm relating to his/her disability(ies) occur to my child when he/she is participating in TOPSoccer.

I hereby declare that _____ has my permission to participate in TOPSoccer.

Signature of Parent or Guardian _____ **Date** _____

Medical Certification Form for TOPSoccer Participation

Player's Name: _____

Address: _____

Phone: _____

Sex: M ___ F ___ Date of Birth: _____ Height: _____ Weight: _____

-
- Note to the Physician – If this child has Down Syndrome, TOPSoccer requires that, in order to participate in TOPSoccer, he/she has a complete radiological examination for the purpose of establishing the absence of atlantoaxial instability.

Physician Statement/Information:

Physician's Name: _____ Office Phone # _____

Address: _____

Physician's Comments: _____

"I have reviewed the above player's health information and examined the player and certify that there is no medical evidence apparent to me that would preclude him/her from participating in TOPSoccer"

Physician's Signature: _____ Date: _____