PARTICIPANT MEDICAL RELEASE FORM

Participant's Name: _____ Date of Birth: _____

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

Club/Program: _____

EMERGENCY INFORMATION

Name: _____ Home Phone: _____ Cell Phone: _____

Name: _____ Home Phone: _____ Cell Phone: _____

Allergies: _____

Other Medical Conditions: _____

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

Medical and/or Hospital Insurance Company: _____

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

PARTICIPANT APPROVAL AND MEDICAL RELEASE

Recognizing the possibility of injury or illness, and in consideration for the Wisconsin Youth Soccer Association (WYSA), US Youth Soccer and members of US Youth Soccer accepting myself as a participant in the soccer programs and activities of WYSA, US Youth Soccer and its members (the "Programs"), I consent to participate in the Programs. Further, I release, discharge, and otherwise indemnify WYSA, 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 me as a result of my participation in the Programs and/or being transported to or from the Programs, which transportation I authorize.

I have received a physical examination by a physician and has been found physically capable of participating in the Programs. I give my consent to have an athletic trainer and/or doctor of medicine or dentistry provide me with medical assistance and/or treatment and agree to be responsible financially for the reasonable cost of each assistance and/or treatment.

I agree that if I may have sustained a concussion or head injury that I am to be removed from the competition until such time that a trained medical professional can examine and approve my return to play soccer. In such case, I understand that I am to provide a written clearance to return to play soccer.

_____ _____

Participant Signature Date

Addendum only for those players having sustained a possible concussion or head injury:

On (date) _____ I sustained a possible concussion or head injury. I have been examined by a trained medical professional and been cleared to participate in soccer activities as of today.

_____ _____

Signature of Medical Professional Date