APYSL - Medical Release

Player Name _____

DOB _____ SEX _____ School Grade in Fall _____

Mailing Address

_____

E-mail Address _____

City/State/Zip _____

Phone _____ SCHOOL _____

MEDICAL CONSIDERATIONS

_____

_____

ALLERGIES/MEDICATIONS

_____

_____

Parent/Guardian:

MOTHER

Name_____

Address_____

Phone_____

FATHER

Name_____

Address_____

Phone_____

OTHER (Grandparent, Aunt, etc)_____

Name_____

Address_____

Phone_____

In case of emergency, please list names, relationship & numbers in priority order of who to contact:

1. _____
2. _____
3. _____

Consent for Treatment

I hereby acknowledge the risks involved in soccer. In the event of injury to my son or daughter, I hereby give my permission for any and all medical attention necessary to be administered to my child.

Health Insurance Company _____

Policy Number_____

Child's Physician_____

Physician Phone #_____

Recognizing the possibility of physical injury associated with soccer and in consideration for APYSL accepting the registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify APYSL, their associated personnel, including the owner 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.

A parent or guardian's signature upon registration will be considered approval of a participant's physical fitness for competitive soccer.

DATE ____/____/____ Parent Signature _____

I have read the Capital District Youth Soccer League Code of Conduct as posted on the league website Information section

Parent Signature_____