

Loudoun Soccer

P.O. Box 1358, Leesburg, VA 20177 Phone: 703-777-9977 www.loudounsoccer.com

TOPSoccer Program Registration Form – Fall 2009

Location: Ida Lee Park or Simpson Middle School in Leesburg

Player Information

Name: _____ Date of Birth _____

Address: _____ Sex: M _____ F _____

City: _____ State: _____ Zip: _____ **Proof of age required.**

Total number of seasons played: _____ Returning Loudoun Soccer Player Yes No

Parent/Guardian Information

Parent(s)/Guardian(s): _____

Address: _____

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

Office Phone # _____ Cellular Phone # _____

E-Mail: _____

Emergency Information

Person to contact in case of emergency: _____

Address: _____

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

Office Phone # _____ Cellular Phone # _____

Fall 2009 Registration Fee - \$35.00
(\$25.00+\$10 Loudoun Co. Usage fee per player)
Please make checks payable to Loudoun Soccer

DO NOT WRITE BELOW

LOUDOUN SOCCER USE ONLY

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Postmark CC _____ Check# _____ Amount\$ _____ Registered BY _____ Entered By _____ Proof of Age _____

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Health Information

	<u>Circle One</u>		<u>Comments</u>
Down Syndrome	Yes	No	_____
Atlantoaxial instability evaluation by x-ray (Circle Yes for Positive, R for Negative)	Yes	R	_____
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: _____

3. General athletic ability compared to non-disabled players of the same age: _____

4. Why is the player being enrolled in TOPSoccer? _____

Special Medication(s)

<u>Medication Name</u>	<u>Amount</u>	<u>Time(s) Usually Taken</u>	<u>Date Prescribed</u>
_____	_____	_____	_____
_____	_____	_____	_____

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

Immunizations

Tetanus Yes No Date of last tetanus shot: _____
 Polio Yes No
 Other(s) (Please List) _____

Doctor(s)

Name: _____ Phone: _____
 Name: _____ Phone: _____
 Name: _____ Phone: _____

SIGNATURE: _____ Date: _____
 Signature of person completing this Participant Information form (Parent, guardian, adult athlete)

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ATHLETE'S APPLICATION/AGREEMENT TO PARTICIPATE

I, _____, wish to participate in youth soccer, and more particularly in the _____ 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 _____ TOPSoccer Program, its sponsoring club/association, and the Virginia 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

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 Loudoun Youth Soccer Association 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 Loudoun Youth Soccer Association TOPSoccer and Virginia Youth Soccer Association (VYSA) 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 Loudoun Youth Soccer Association 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** _____

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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: _____

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Atlanto-axial Instability Certification

Important Note: **If your child has Down Syndrome, he/she must have a complete radiological examination for the purpose of establishing the absence of atlanto-axial instability.**

Player Information

Player's Name: _____

Date Of Birth: ____/____/____ Height: _____ Weight: _____

Parent/Guardian Information

Name: _____

Address: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Physician Statement/Information

Family Physician: _____ Phone: (____) _____

Address: _____ City, State: _____

Physician's Comments: _____

"I have reviewed the above player's health information, 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: _____