



# NEW MEXICO YOUTH SOCCER ASSOCIATION

The governing body for youth soccer in New Mexico, affiliated with the United States Youth Soccer Association (USYSA), the United States Soccer Federation (USSF), and the Fédération Internationale de Football Association (FIFA)

## PLAYER INFORMATION AND MEDICAL RELEASE FORM

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### EMERGENCY INFORMATION:

Father's Name: \_\_\_\_\_ Phone: Hm (\_\_\_\_) \_\_\_\_\_ Ofc (\_\_\_\_) \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone: Hm (\_\_\_\_) \_\_\_\_\_ Ofc (\_\_\_\_) \_\_\_\_\_

In an emergency when parents cannot be reached, please contact:

Name: \_\_\_\_\_ Phone: Hm (\_\_\_\_) \_\_\_\_\_ Ofc (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Phone: Hm (\_\_\_\_) \_\_\_\_\_ Ofc (\_\_\_\_) \_\_\_\_\_

Allergies: \_\_\_\_\_

Other medical conditions: \_\_\_\_\_

Player's Physician: \_\_\_\_\_ Phone: Hm (\_\_\_\_) \_\_\_\_\_ Ofc (\_\_\_\_) \_\_\_\_\_

Medical and/or Hospital Insurance Co.: \_\_\_\_\_ 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/USYSA and its affiliate accepting the registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify the USSF/USYSA, its affiliated organizations and sponsors, their employees and associated personnel, including the owners 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.

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

MY COMMISSION EXPIRES \_\_\_\_\_



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