HEALTH INFORMATION:

Does your child need to use a wheelchair or walker? Wheelchair Walker Neither **Circle one**

Briefly describe your child's physical and medical condition: _____

_____

Down syndrome	Yes	No
Atlantoxial Instability Evaluation by X-Ray	Yes (positive)	No (negative)

HISTORY:

Diabetes	Yes/No	Bleeding Problem	Yes/No
Heart problems/Blood pressure elevation	Yes/No	Fainting	Yes/No
Seizures	Yes/No	Bone or joint problems	Yes/No
Hearing aid/Hearing problem	Yes/No	Dentures/False teeth	Yes/No
Motor impairment requiring special equip.	Yes/No	Special diet needs	Yes/No
Head injury/History of concussion	Yes/No	Recent contagious disease or hepatitis	Yes/No
Heat illness or cold injury	Yes/No	Other (provide details below)	
Kidney problems or loss of function in one	Yes/No	_____	
Vision problems	Yes/No	_____	
Contact lenses/glasses	Yes/No	_____	
Emotional problems	Yes/No	_____	

PHYSICIANS NAME:_____PHONE_____

MEDICATIONS AND DOSAGES (list all)

_____

_____

_____

Allergies to Medication:_____

Immunizations:
Date of last tetanus shot_____

WAIVER OF LIABILITY

I, the parent/guardian of the registrant, a minor, agree that the registrant and I will abide by the rules of Madison TOP Soccer, the Ohio Youth Soccer Association North and its affiliated organizations and sponsors. Recognizing the possibility of physical injury associated with soccer and in consideration for Madison TOP Soccer and OYSAN accepting the registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify Madison TOP Soccer, the OYSAN, its affiliated organizations and sponsor and 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.

CONSENT FOR MEDICAL TREATMENT

As the parent or legal guardian of the above-named player, I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.

Signature _____ Relationship_____ Date _____