

EAGLES TOPSoccer Program

New Participant Information

Office use	
AI	
SOMA	
FEE	

Athlete Information

Name: _____ Date of Birth _____

Address: _____

City: _____ State: ____ Zip: _____ Phone # _____

Sex: M _____ F _____

UNIFORM (circle one)

Shirt YS YM YL AS AM

Shorts YS YM YL AS AM

Socks S M L

Sweatshirt YS YM YL AS AM

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 # _____

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	_____
Autism (PPD-NOS)	Yes	No	_____

Cerebral Palsy	Yes	No	_____
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History of: Circle One Comments

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	_____
Recent contagious disease(s) or hepatitis	Yes	No	_____
Explain if Yes	_____		
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:

Special Medication(s)

Medication Name Amount Time(s) Usually Taken Date Prescribed

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

Doctor(s)

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Signature

Signature of person completing this Participant Information form
(Parent, guardian)

_____ Date: _____

Eagles TOPSoccer Program

PARENTAL CONSENT FOR EAGLES 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 EAGLES 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 Eagles 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 Eagles 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 Eagles TOPSoccer.

I further understand that my presence or the presence of my spouse or other legal guardian is required at all Eagles TOPSoccer and Massachusetts Youth Soccer Association (Mass Youth Soccer) 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 Eagles TOPSoccer activities is based in part on issues surrounding emergency care should it be needed.

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 Eagles TOPSoccer and agree to hold harmless the Eagles 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 Eagles TOPSoccer.

In permitting my son/daughter to participate in the Eagles TOPSoccer Program, I specifically grant my permission for Eagles 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 Eagles TOPSoccer and/or seeking funds and other types of support for Eagles TOPSoccer.

I hereby declare that _____ has my permission to participate in Eagles TOPSoccer.

Signature of Parent or Guardian _____ **Date** _____