Player Last Name: ____________

MEDICAL RELEASE

I hereby grant permission for any and all medical attention to be administered to my child (listed below) in the event of accident, injury, sickness, etc. under the direction of the person(s) listed below, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below. I understand that FYSA recommends that players not register to a team whose age group exceed the player's normal age.

Insurance Notice

All injuries must be reported within 90 days of the date of injury. Benefits will be provided for eligible expenses not paid by other insurance health plans after the FYSA deductible has been satisfied.

Informed Consent

I acknowledge that I am completely aware of the inherent risks associated with soccer, from minor injuries to paralysis or other serious, permanent injuries including death, and hereby waive, release, and discharge the state association (FYSA) and all of its affliated organizations, including the owners of fields and facilities used for the programs, as well as their officers, directors, employees and agents (collectively, the "Released Parties"), from any and all liability and responsibility in the event that my child become injured in any way during his/her participation in soccer events or activities associated with the Released Parties. I further state that I take full responsibility for any injury that may occur as a result of his/her participation, and that I will not hold the Released Parties responsible for any aggravation of preexisting injuries prior to or during his/her participation in any soccer events or activities associated with the Released Parties. Knowing these risks, I give permission for my child to participate in soccer and further agree to abide by all rules associated with PDA Florida and all affiliated organizations.

Player Information

Player Name: ____________

Address : ____________

City / State / Zip : ____________

Home Phone: ____________ Cell Phone: ____________

Other Contacts: ____________

Insurance Co. ____________

Policy Number: ____________

Physician Name: ____________ Phone: ____________

Known Allergies ____________ Phone: ____________

Other Medical Information ____________ Phone: ____________

In case I cannot be reached, any of the following persons are designated to act on my behalf:

Coach ____________

Assistant Coach ____________

Other ____________

A League Representative where my child is playing OR Any tournament representative where my child is participating

Signature of Parent / Guardian ____________ Phone: ____________

Date: ____________

FORM DOES NOT NEED TO BE NOTARIZED