

SUFFOLK YOUTH ATHLETIC ASSOCIATION
P.O. 3081, SUFFOLK, VA 23434-3081 TEL: 757-539-5095

MEDICAL HISTORY FORM

Player's Last Name: _____ First: _____ MI: _____

Home Phone Number: _____ Cell: _____ Gender: M or F

PARTICIPANTS MEDICAL HISTORY

1. Does the participant have any allergies (bee stings, foods, etc.)? YES NO

2. Does the participant have asthma/ require the use of an inhaler? YES NO

If yes, please bring inhaler to all practices and games.

3. Is the participant diabetic/require medication for diabetes? YES NO

If yes, please bring medication if necessary to all games and practices.

4. Does the participant have/had seizures? YES NO

5. Does the participant wear glasses or contact lenses? YES NO

6. Does the participant have trouble hearing/wear aids? YES NO

If you answered yes to any of the above questions, please provide the question number and an explanation in the following space:

I hereby certify that this information is accurate to the best of my knowledge. Furthermore, I hereby acknowledge that it is my responsibility to inform my child's coach or organization in writing if there is any change in the medical condition of my child.

Signature of Parent or Guardian: _____

Print Name: _____

Relationship to Participant: _____

Witness: _____

Print Name: _____ Date: _____

DISCLAIMER & RELEASE OF LIABILITY: I recognize and understand that soccer is a sport involving risks not encountered in everyday play. With this understanding, in consideration of Suffolk Youth Athletic Association (SYAA), permitting my child to participate in the youth soccer program, I covenant and agree to indemnify and hold harmless and do release, requite and forever discharge, SYAA, Virginia Soccer League, Inc. (VSLI), Tidewater Advanced Soccer League, Inc. (TASL), Virginia Youth Soccer Association (VYSA), Soccer Association for Youth (SAY) their officers, Board of Directors, employees, coaches, referees and other such volunteers as are connected with SYAA, VSLI, TASL, VYSA, and SAY in any capacity, for any and all damages, claims, and/or liability arising out of any and all injury to or caused by my child. With the knowledge and understanding of the foregoing, this is to certify that my child has my permission to play in the SYAA program. I hereby certify that my child has no known medical problems which would preclude participation in team sports. In the event the above named player is injured and requires medical attention, I authorize medical treatment as may be deemed necessary in my absence. I hereby authorize any and all emergency medical treatment deemed necessary by any physician, nurse, or paramedic. A copy of this authorization shall be as effective as the original. I agree to abide by the rules & bylaws of SYAA. I certify that all information given above is correct. I understand this is a legal document. By signing below I grant permission for SYAA to publish pictures of my family on the league's web site or in the league's press releases, publicity information, newsletters or bulletins. I understand that if I give notice to the webmaster or the board that I object to any particular picture on the web site, etc. it will be removed.