



**Northern New York Soccer Academy Team
Player Registration and Medical Release Form**

Player's Name: _____ Date of Birth (mm/dd/yy) _____

Address: _____ City: _____

State: _____ Zip: _____

Sex: (circle) Male / Female

Parents Email: _____

Shirt Size: YS, YM, YL, AS, AM, AL, AXL (Circle One)

EMERGENCY INFORMATION:

Name: _____ Home Phone: _____ Cell Phone: _____

Name: _____ Home Phone: _____ Cell Phone: _____

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

Name: _____ Home Phone: _____ Cell Phone: _____

Name: _____ Home Phone: _____ Cell Phone: _____

Allergies: _____

Other Medical Conditions: _____

Player's Physician: _____ Phone: _____

Medical and/or Hospital Insurance Company: _____ Phone: _____

PLEASE COPY BOTH SIDES OF YOUR INSURANCE CARD AND ATTACH TO THIS FORM

PARENT'S APPROVAL AND MEDICAL RELEASE

Recognizing the possibility of injury associated with soccer and in consideration for the Northern New York Academy Team, (NNY Academy), Northern New York Youth Soccer League (NNYYSL), New York State West Youth Soccer (NYSWYSA), US Youth Soccer (USYS), the US Soccer Federation (USSF) and their affiliates accepting the registrant for their soccer programs and activities ("the Programs"), I hereby release, discharge and/or otherwise indemnify the NNY Academy/NNYYSL/NYSWYSA/USYS/USSF, their affiliated organizations and sponsors, their employees and associated personnel, including the owner of fields or facilities utilized for the Programs against any claim by or in 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 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 each assistance and/or treatment.

Signature of Parent/Guardian Date

Date