Westport Soccer Association

PO Box 2561 • Westport CT 06880 • (203) 221-9900
www.westportsoccer.org

TRAVEL SOCCER 2017-2018
RELEASE and MEDICAL AUTHORIZATION

RELEASE: I, the undersigned, am the parent or legal guardian of the registrant, a minor, and hereby agree that the registrant will abide by the rules of the United States Youth Soccer Association (USYSA), its affiliated organizations and sponsors. I recognize that soccer is a rigorous sport and the possibility of physical injury exists for participants in games, tournaments, practices and clinics. In consideration for the USYSA accepting the registrant for its soccer programs and activities ("the Programs"), I hereby release, discharge and/or otherwise indemnify the USYSA, its affiliated organizations and sponsors, their employees and associated personnel, including team coaches, game officials, and the owners of the 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/from the same, which transportation I hereby authorize.

MEDICAL AUTHORIZATION I, the undersigned, am the parent or legal guardian of the registrant, a minor, and do hereby give my permission for the registrant to receive any and all medical treatment, assistance, or care administered by any duly licensed physician or hospital in the event of an injury, accident or sickness while he/she is being transported to, or is attending or participating in any game, practice, clinic or other event conducted or sponsored by the USYSA or its affiliated organizations, until such time as I may be contacted. I also hereby assume the responsibility for the payment of any such treatment.

Please complete and print the following:

I confirm that my child, the registrant, _______________________________, is covered by a medical
First and Last Name
insurance policy (name & number) ______________________________ provided by family or otherwise.

This Release and Medical authorization is effective for 15 months from the date given below.

MEDICAL INFORMATION:

Child's **Physician** Information: Name: ___________________________ Phone: ________________

Child's known allergies or special needs: _________________________ **DOB:** ________________

SCHOOL AND GRADE as of **Fall 2017** ____________

TEAM: (e.g. U11 GIRLS WHITE**) U____ GENDER ______ COLOR________**

CODE OF CONDUCT: I certify that both I and my child have read, understood and agree to abide by the rules and regulations stated in the WSA Code of Conduct for Players and Parents. We understand we are bound to all decisions and impositions of these rules.

I, the undersigned, have carefully read the foregoing releases, authorizations and conduct rules and understand the content thereof. It is with the spirit of cooperation for the betterment of the WSA program and my child's participation in it, that I willingly sign below.

Parent signature ________________________________ Email: __________________________

Print Name: ____________________________________ Date: _________________
First and Last Name

Address: ____________________________________ Phone: _______________________

Revised April 8, 2017