OLYMPIC DEVELOPMENT PROGRAM
PLAYER MEDICAL RELEASE FORM

PLAYER'S NAME________________________ SEX ___M ___F DATE OF BIRTH__________

ADDRESS________________________CITY__________STATE_____ZIP________

* SOCIAL SECURITY NUMBER _____-_____-_____ EMAIL ADDRESS ______________

EMERGENCY INFORMATION

MOTHER'S NAME____________________HM PH (____)________WK PH (____)________

FATHER'S NAME____________________HM PH (____)________WK PH (____)________

IN AN EMERGENCY WHEN PARENTS CANNOT BE REACHED, PLEASE CONTACT:

NAME________________________ RELATIONSHIP ______________

HOME PHONE (____)________ WORK PHONE (____)________ CELL PHONE (____)________

NAME________________________ RELATIONSHIP ______________

HOME PHONE (____)________ WORK PHONE (____)________ CELL PHONE (____)________

ALLERGIES____

OTHER MEDICAL CONDITIONS__________________________________

PLAYERS PHYSICIAN____________________HM PH (____)________WK PH (____)________

MEDICAL AND/OR HOSPITAL INS. CO.__________________________PH (____)________
(PLEASE COPY BOTH SIDES OF YOUR MEDICAL INSURANCE CARD AND ATTACH TO THIS FORM)

POLICY HOLDER ____________________POLICY #____________GROUP #________

PARENTS APPROVAL AND MEDICAL RELEASE

RECOGNIZING THE POSSIBILITY OF PHYSICAL INJURY ASSOCIATED WITH SOCCER AND IN CONSIDERATION FOR THE USSF/USYSA AND ITS AFFILIATES ACCEPTING THE REGISTRANT FOR ITS SOCCER PROGRAMS AND ACTIVITIES (THE "PROGRAMS"), I HEREBY RELEASE, DISCHARGE, AND/OR OTHERWISE INDEMNIFY THE USSF/USYSA, IT'S AFFILIATED ORGANIZATIONS AND SPONSORS, THEIR EMPLOYEES AND ASSOCIATED PERSONNEL, INCLUDING THE OWNERS OF 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 "PROGAMS" 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 THE "PROGRAMS". I HEREBY GIVE 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 SUCH ASSISTANCE AND/OR TREATMENT.

SIGNATURE OF PARENT/GUARDIAN________________________________**DATE**__________

PRINT PARENT/LEGAL GUARDIAN NAME ________________________

OLYMPIC DEVELOPMENT PROGRAM-BOYS & GIRLS
MEDICAL HISTORY QUESTIONNAIRE

LAST NAME________________ FIRST NAME________________ MIDDLE INITIAL______

ADDRESS________________ CITY________________ STATE______ ZIP______

DATE OF BIRTH_____-_____-_____ SEX ____M ____F SOCIAL SECURITY NUMBER_____-_____-_____

EMERGENCY CONTACT________________ HM PH (____)__________ WK PH (____)__________

PLEASE CIRCLE EITHER **"YES"** OR **"NO"** TO ALL QUESTIONS AND PROVIDE ADDITIONAL DETAILS WHERE REQUESTED. YOU MAY PUT DETAILS ON THE BACK OF THIS FORM IF NEEDED. ALL INFORMATION IS CONFIDENTIAL.

1) ARE YOU ALLERGIC TO ANY MEDICATION (ASPIRIN, PENICILLIN, SULFA, ETC)? **YES NO** (LIST)________________
2) DO YOU TAKE ANY PRESCRIBED MEDICATION ON A PERMANENT BASIS OR SEMI-PERMANENT BASIS (STEROIDS, BIRTH CONTOL PILLS, ANIT-INFLAMMATORIES, ANTIBIOTICS, ETC)? **YES NO** (IF YES, ATTACH A LIST, DOSASAGE & GIVE REASON)
3) HAVE YOU EVER HAD A SIEZURE? **YES NO**
4) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE EPILEPSY? **YES NO**
5) HAVE YOU EVER BEEN TREATED FOR DIABETES? **YES NO**
6) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU WERE ANEMIC? **YES NO** WHEN?________________
7) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE SICKLE CELL ANEMIA? **YES NO**
8) HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE SICKLE CELL TRAIT? **YES NO**
9) DO YOU HAVE OR HAVE YOU EVER HAD HIGH BLOOD PRESSURE? **YES NO**
10) DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING DISEASES?
    HEART DISEASE (HEART MURMER, RHEUMATIC FEVER) **YES NO**
    LUNG DISEASE (PNEUMONIA) **YES NO**
    KIDNEY DISEASE (INFECTIOUS) **YES NO**
    LIVER DISEASE (MONONUCLEOSIS, HEPATITIS) **YES NO**
11) DO YOU HAVE OR HAVE YOU EVER BEEN TOLD BY A DOCTOR THAT YOU HAVE ASTHMA? **YES NO**
12) DO YOU HAVE OR HAVE YOU EVER HAD A HERNIA OR "RUPTURE"? **YES NO** HAS IT BEEN REPAIRED?__________ DATE______
13) HAVE YOU EVER BEEN "KNOCKED OUT"(UNCONSCIOUS) IN THE PAST 3 YEARS? **YES NO**
14) HAVE YOU EVER HAD A CONCUSSION OR OTHER HEAD INJURY IN THE PAST 3 YEARS? **YES NO**
15) HAVE YOU STAYED OVERNIGHT IN THE HOSPITAL DUE TO A HEAD INJURY? **YES NO**
16) HAVE YOU EVER HAD A NECK INJURY INVOLVING BONES, NERVES, OR DISKS THAT DISABLED YOU FOR A WEEK OR LONGER? **YES NO** TYPE OF INJURY________________ DATES__________
17) DO YOU WEAR GLASSES OR CONTACTS DURING COMPETITION? **YES NO**
18) DO YOU WEAR ANY OF THE FOLLOWING DENTAL APPLIANCES? **YES NO** (CIRCLE THOSE WHICH APPLY) PERMANENT BRIDGE, BRACES, REMOVABLE RETAINER, PERMANENT RETAINER, REMOVABLE PARTIAL PLATE, FULL PLATE, PERMANENT CROWN OR JACKET?
19) HAVE YOU HAD A BROKEN BONE OR FRACTURE IN THE PAST 2 YEARS? **YES NO** ____RIGHT OR____LEFT
    WHAT BONE(S)________________ DATES__________
20) HAVE YOU EVER HAD A SHOULDER INJURY IN THE PAST 2 YEARS THAT DISABLED YOU FOR A WEEK OR LONGER? (DISLOCATION, SEPARATION, ETC) **YES NO** ____RIGHT OR____LEFT TYPE OF INJURY________________ DATE__________
21) HAVE YOU EVER HAD SHOULDER SURGERY? **YES NO** ____RIGHT OR ____LEFT DATE__________
    WHAT WAS DONE AND WHY?________________
22) HAVE YOU EVER INJURED YOUR BACK? **YES NO** TYPE OF INJURY________________ DATE__________
23) DO YOU HAVE BACK PAIN? **YES NO** (CIRCLE THOSE THAT APPLY) SELDOM, OCCASIONALY, FREQUENTLY, WITH VIGOROUS EXERCISE
24) HAVE YOU INJURED YOUR KNEE IN THE PAST 2 YEARS? **YES NO** ____RIGHT OR ____LEFT DATE__________
25) HAVE YOU BEEN TOLD BY A DOCTOR OR ATHLETIC TRAINER THAT YOU INJURED THE CARTILAGE IN YOUR KNEE? **YES NO** ____RIGHT OR ____LEFT DATE__________
26) HAVE YOU BEEN TOLD BY A DOCTOR OR ATHLETIC TRAINER THAT YOU INJURED THE LIGAMENTS IN YOUR KNEE? **YES NO** ____RIGHT OR ____LEFT DATE__________
27) HAVE YOU HAD KNEE SURGERY? **YES NO** ____RIGHT OR ____LEFT WHAT WAS DONE?__________ DATE______
28) HAVE YOU HAD A SEVERE ANKLE SPRAIN IN THE PAST 2 YEARS? **YES NO** ____RIGHT OR ____LEFT DATE______
29) DO YOU HAVE A PIN, SCREW, OR PLATE IN YOUR BODY? **YES NO** LOCATED WHERE__________ DATE______
30) DO YOU HAVE OTHER CONDITIONS THAT WE SHOULD BE AWARE OF (I.E. PREGNANCY, FOOD OR INSECT ALLERGIES,TENDINITIS, ETC)? **YES NO** (SPECIFY & GIVE DETAILS)________________
31) DATE OF LAST IMMUNIZATION: ______TETANUS ______POLIO ______MUMPS ______RUBELLA ______MEASLES

THE QUESTIONS ON THIS FORM HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.

PARENT/GUARDIAN SIGNATURE________________ **DATE**__________

ATHLETE'S SIGNATURE________________ **DATE**__________