

Virginia Youth Soccer Association
Chantilly Youth Soccer
TOPSoccer Club-Participant Information Form

SEASON: Fall____Winter____Spring____2008

Athlete Information

Name: _____ Male____Female____

Birthdate: ____/____/____ Age: ____ Circle T-Shirt Size: YS YM YL AS AM AL AXL

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Social Security # _____

Parent/Guardian Information

Parent(s)/ Guardian(s): _____

Work Phone: 1. _____ 2. _____

Cell Phone: 1. _____ 2. _____

Email Address: 1. _____ 2. _____

Emergency Contact Information

Name	Address	Relationship
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Home Phone	Office Phone	Cell Phone
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Physician Contact Information

Name: _____ Phone: _____

Name: _____ Phone: _____

Immunizations

Tetanus: YES NO Date of last tetanus shot _____ Polio: YES NO

Others(Please list) _____

Health Information

Circle One

Comments

Down Syndrome	Yes	No	_____
Atlantoaxial Instability Evaluation (Circle Yes for Positive and R for Negative)	Yes	R	_____

History of:

Atlantoaxial Instability	Yes	No	_____
Diabetes	Yes	No	_____
Heart problems/blood pressure elevation	Yes	No	_____
Seizures	Yes	No	_____
Vision problems, and/ or less than 20/20 vision in one or both eyes	Yes	No	_____
Hearing Aid/hearing problem	Yes	No	_____
Motor impairment requiring special equipment	Yes	No	_____

Types of special equipment/ aid used _____

Bleeding Problems	Yes	No	_____
Head Injury/History of Concussion	Yes	No	_____
Fainting/ Dizzy Spell	Yes	No	_____
Heat Illness or Cold Injury	Yes	No	_____
Hernia or Absence of one testicle	Yes	No	_____
Recent contagious disease(s) or hepatitis	Yes	No	_____

If yes, please explain: _____

Kidney problems or loss of function in one	Yes	No	_____
Urinary Problems/Incontinence	Yes	No	_____
Pregnancy	Yes	No	_____
Bone or Joint Problems	Yes	No	_____
Contact lenses or glasses	Yes	No	_____
Dentures/false teeth/implants	Yes	No	_____
Emotional problems	Yes	No	_____
Special dietary needs/ allergies	Yes	No	_____
Other	Yes	No	_____

1. Medical condition(s) the coaching staff should be aware of: _____

2. Behavioral information that may be of help to our coaching staff:_____

3. General athletic ability compared to non disabled players of the same age:_____

4. Why is player being enrolled in TOPSoccer?_____

Special Medication(s)

Medication Name **Amount** **Time(s) Usually Taken** **Date Prescribed**

Know allergies/adverse reactions to medications and foods:

Additional Comments

Signature

Signature of person completing this VYSA/CYA TOPSoccer Participant Information form:
(Parent, guardian, adult athlete)

Signed_____ Date_____

Relationship_____

Print Your Name _____