



FALL 2009

## Mississippi Coast Special Needs Soccer Association Participant Registration

### ATHLETE INFORMATION:

Player's Name: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_ Email Add: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex(circle one): M/F Height: \_\_\_\_\_

Weight: \_\_\_\_\_ Birth Certificate Number: \_\_\_\_\_

### EMERGENCY INFORMATION:

Person to Contact in Case of Emergency: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

#### SHIRT SIZE: (Circle One)

|       |       |       |       |  |       |       |       |       |       |
|-------|-------|-------|-------|--|-------|-------|-------|-------|-------|
| XS    | S     | M     | LG    |  | S     | M     | L     | XL    | XXL   |
| Child | Child | Child | Child |  | Adult | Adult | Adult | Adult | Adult |

#### SHORT SIZE

|    |   |   |    |  |   |   |   |    |     |
|----|---|---|----|--|---|---|---|----|-----|
| XS | S | M | LG |  | S | M | L | XL | XXL |
|----|---|---|----|--|---|---|---|----|-----|

### HEALTH INFORMATION:

Down syndrome Yes                  No  
 Atlantoaxial Instability Evaluation by X-Ray Yes (positive) No (negative)

#### HISTORY:

|  |        |                           |        |
|--|--------|---------------------------|--------|
| Diabetes                                   | Yes/No | Bleeding Problem          | Yes/No |
| Heart problems/Blood pressure elevation    | Yes/No | Fainting Spells           | Yes/No |
| Seizures                                   | Yes/No | Bone or joint problems    | Yes/No |
| Hearing aid/Hearing problem                | Yes/No | Dentures/False teeth      | Yes/No |
| Motor impairment requiring special equip.  | Yes/No | Special diet needs        | Yes/No |
| Head injury/History of concussion          | Yes/No | Recent contagious disease | Yes/No |
| Heat illness or cold injury                | Yes/No | Other                     | Yes/No |
| Kidney problems or loss of function in one | Yes/No | Food Allergies            | Yes/No |
| Vision problems                            | Yes/No |                           |        |
| Contact lenses/glasses                     | Yes/No |                           |        |
| Emotional problems                         | Yes/No |                           |        |

1. Medical Condition of which the coaching staff should be aware:
  
2. Behavioral information that may help the coaching staff.
  
3. General athletic ability when compared to non-disabled players of the same age.
  
4. Why is the player being enrolled in TOP Soccer?
  
5. Other information you would like us to know about your child.
  
6. Does your child require physical assistance? Or the use of a walker or wheelchair, etc?

**MEDICATIONS:**

Medication Name

Other Information

\_\_\_\_\_

Allergies to Medication: \_\_\_\_\_

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**IMMUNIZATIONS:**

Tetanus: Yes / No      Date of last tetanus shot: \_\_\_\_\_ Polio: Yes / No

**DOCTOR:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

By signing below I give permission for my child to participate in TOP Soccer:

**Signature of Person Completing Registration Information**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Registration Fee: \$20.00

Mississippi Coast Special Needs Soccer Association  
 13136 Lorraine Road  
 Biloxi, MS 39532

## PHOTOGRAPHIC RELEASE

With this release I hereby give my permission for use of photographs taken by the Mississippi Coast Special Needs Soccer Association, in advertising or promotion.

It is my understanding that these photographs will be used in accordance with the highest standards of good taste and advertising ethics, and in consideration of this, I do hereby relinquish ownership and assume full responsibility for any and all repercussions resulting from the publication of any photograph's.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Parent or Legal Guardian if applicant is under 19

\_\_\_\_\_

**PARENTAL CONSENT FORM**  
**RELEASE TO BE COMPLETED BY PARENT OR GUARDIAN**

I am the parent/guardian of \_\_\_\_\_, on whose behalf I have submitted the attached application for participation in **Mississippi Coast Special Needs Soccer Association**. I hereby represent that he/she has my permission to participate in TOP SOCCER.

I further represent and warrant that to the best of my knowledge and belief, he/she is physically and mentally able to participate in the **Mississippi Coast Special Needs Soccer Association**. I understand that if he/she has Down Syndrome, a full radiological examination to establish the absence of Atlanto-axial Instability is needed.

In permitting him/her to participate, I am specifically granting my permission, (both during and any time after) to **Mississippi Coast Special Needs Soccer Association** to use his/her likeness, name, voice and words in television, radio film and or newspapers, magazines and other media, and in any form, for the purpose of advertising or communicating the purpose of activities of Mississippi Coast Special Needs Soccer Association and/or for fund raising to support this program.

If a medical emergency should arise during his/her participation **Mississippi Coast Special Needs Soccer Association**, at a time when I am not personally present so as to be consulted regarding his/her care, I hereby authorize **Mississippi Coast Special Needs Soccer Association**, on my behalf, to take whatever measures are necessary to ensure that he/she is provided with any emergency medical treatment, including hospitalization, which **Mississippi Coast Special Needs Soccer Association** deems advisable in order to protect his/her health and well being.

**Consent for medical Treatment:** As an adult player or the parent or legal guardian of the above named player, I hereby give my consent for emergency medical treatment as described by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions that is necessary to preserve life, limb or well being. As an adult or the parent or legal guardian of the above named player, I agree to abide by the rules of Mississippi Coast Special Needs Soccer Association, Mississippi Soccer Organization and its affiliated sponsors or organizations. Recognizing there exists a risk of physical injury associated with soccer, and in consideration for the Mississippi Coast Special Needs Soccer Association accepting me into its soccer programs and activities, I hereby release, discharge, and/or otherwise indemnify the Mississippi Coast Special Needs Soccer Association, its affiliated organizers and sponsors, their employees and associated personnel including the owners of the fields utilized for the soccer program against any claim by or on behalf of myself as a result of my participation in the program.

The Mississippi Coast Special Needs Soccer Association has secondary medical insurance through the Mississippi Youth Soccer Association. There is a \$250.00 deductible paid by the parent or guardian in the event of injury or medical treatment is needed.

I have read and fully understand the provisions of the above release. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and that of my child. I hereby give permission for him/her to participate in **Mississippi Coast Special Needs Soccer Association**.

Parent or Guardian Signature \_\_\_\_\_

Parent or Guardian (print name) \_\_\_\_\_

Date \_\_\_\_\_