



# Madison Area Youth Soccer Association Player Registration Form



PLAYER'S LAST NAME: \_\_\_\_\_ PLAYER'S FIRST NAME: \_\_\_\_\_ M OR F: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ BIRTHDATE (MM/DD/YY): \_\_\_\_/\_\_\_\_/\_\_\_\_ MOTHER'S BIRTHDATE (MM/DD): \_\_\_\_/\_\_\_\_

FAMILY E-MAIL: \_\_\_\_\_ SCHOOL: \_\_\_\_\_ GRADE ENTERING IN FALL: \_\_\_\_\_

PARENT/GUARDIAN NAME: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

PARENT/GUARDIAN NAME: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

NAME OF PREVIOUS TEAM: \_\_\_\_\_ COACH'S NAME: \_\_\_\_\_ UNIFORM SIZE(X): YM \_\_\_ YL \_\_\_ AS \_\_\_ AM \_\_\_ AL \_\_\_

PARENT WOULD LIKE TO (X) COACH : \_\_\_\_\_ ASSIST COACH: \_\_\_\_\_ MANAGER: \_\_\_\_\_ OTHER: \_\_\_\_\_

MY CHILD QUALIFIES FOR OUR SCHOOL'S FREE OR REDUCED LUNCH PROGRAM (X): \_\_\_\_\_

COMMENTS OR REQUESTS FOR TEAM SELECTION: \_\_\_\_\_

NAME OF PHYSICIAN: \_\_\_\_\_ CLINIC: \_\_\_\_\_ PHONE: \_\_\_\_\_

ALLERGIES OR HEALTH CONDITIONS: \_\_\_\_\_

MEDICAL AND/OR HOSPITAL INSURANCE CO: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_ POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP TO CHILD: \_\_\_\_\_

### PARENT/GUARDIAN APPROVAL AND MEDICAL RELEASE

Recognizing that soccer is a vigorous contact sport which may cause serious physical injury to a participant at a game, tournament, training or scrimmage, by player contact with other players, goalposts, ground, motor vehicles or adult participants, in inclement weather, on variable field conditions - and in consideration for the US Youth Soccer, Wisconsin Youth Soccer Association (WYSA) and Madison Area Youth Soccer Association (MAYSA) accepting my son/daughter as a player in the soccer programs and activities of the above, I consent to my son/daughter participating in those programs. Further, I release, discharge, and otherwise indemnify US Youth Soccer, WYSA, and MAYSA, their employees, associated personnel, referees and volunteers, including the owner of fields and facilities utilized for the programs, against any claim by or on behalf of my player son/daughter as a result of my son's/daughter's participation in the programs and/or being transported to or from the programs, which transportation I authorize, pursuant to the recreational assumption of the risk statute, sec.895.525, Wis. Stats.

My player son/daughter has received a physical examination by a physician and has been found physically capable of participating in the programs. I give my consent to have an athletic trainer, emergency medical care personnel, 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.

I have read, understand and will abide by MAYSA Code of Ethics and Conduct and will to the best of my ability assure that my child/player will also behave according to its tenets including the Zero Tolerance Policy regarding referee abuse.

I hereby grant the MAYSA permission to use my likeness, or the likeness of my minor child or children in a photograph in any and all of its publications, including website entries, printed or other media, whether now known or hereafter existing, controlled by MAYSA, in perpetuity, and for other use by MAYSA without further consideration. I hereby irrevocably authorize WYSA to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing MAYSA's programs or for any other lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears.

Please note that the Registrant shall not be permitted to participate in any US Youth Soccer, WYSA, and/or MAYSA programs unless and until this form is signed and returned to an authorized MAYSA representative.

I have read and fully understand the above statements.

**SIGNATURE OF PARENT OR LEGAL GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

CLUB: _____	<u>Coaches/Registrars: Complete this Section</u>
Team Name: _____	Div: _____ Age Group U- _____ Girls _____ or Boys(Coed) _____ Coach: _____

# Parent & Athlete Concussion Information Sheet

Reformatted from the Center for Disease Control's Heads Up Concussion in Youth Sports Program

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by bump, blow, or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

## WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If an athlete reports **one or more** symptoms of concussion listed below after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

### Signs Observed by Coaching Staff

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events *prior* to hit or fall
- Can't recall events *after* hit or fall

### Symptoms Reported by Athletes

- Headaches or “pressure” in the head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to noise
- Feeling sluggish, hazy, foggy or groggy
- Concentration or memory problems
- Confusion
- Just not “feeling right” or “feeling down”

## CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that not only does not diminish, but gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech

- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

## WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

## WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

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I have reviewed [MAYSA's Concussion Awareness Information](#) and I agree that if it appears that my child may have sustained a concussion or head injury that he/she is to be removed from any program activity until such time that a trained medical professional can examine him/her and approve their return to play soccer, pursuant to Wisconsin Act 172 relating to concussions and other head injuries. In such case, I understand that I am to provide a *written* clearance from a trained medical professional for my player to return to play soccer.

I have read and fully understand this statement regarding concussions.

SIGNATURE OF PARENT OR LEGAL GUARDIAN: \_\_\_\_\_

DATE: \_\_\_\_\_