# EMERGENCY MEDICAL RELEASE & LIABILITY WAIVER

**Player's Name:** _____ **Birth Date:**_____/_____/_____

**Address:**_____

**Parent #1:**_____ **Phone:**_____ **Parent #2:**_____ **Phone:**_____

**In the case when parent/guardian cannot be reached or if is not applicable, please contact the following:**

**Emergency contact:**_____ **Phone:**_____

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**Last medical visit**_____/_____/_____ **Physician:**_____ **Phone:**_____

**Medical/Hospital Insurance Company:**_____ **Phone:**_____ **Number of policy:**_____

**Policy Holder's Name:**_____

**Have you traveled outside US before?** ☐ **Yes** ☐ **No**

**Are you on any medication?** ☐ **Yes** ☐ **No** **If yes, which ones** _____

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THIS AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT MUST BE COMPLETED BEFORE THE PARTICIPANT (PLAYER/COACH/REFEREE) CAN PARTICIPATE IN NI ACTIVITIES. TREATMENT FOR INJURY WILL BE BASED ON THE INFORMATION PROVIDED HEREIN.

I, the participant and/or parent/guardian of the above-listed minor (if the participant is under the age of 18) acknowledge and fully understand that each participant will be engaging in activities that involve risk of serious injury, including permanent disability or death, and severe social and economic losses which might result not only from their actions, inactions, or negligence, but from action, inaction, or negligence of others, the rules or play, or the condition of the premises or any equipment used, and further, that there may be other unknown risks not reasonably foreseeable at this time.

Also, I assume all the foregoing risk and accept personal responsibility for the damages following such injury, permanent disability, or death, hereby release, discharge, covenants not to sue Futsoccer International, its directors, officers, employees, coaches, managers, agents, sponsors, and associated personnel including those of its affiliated organizations, and the owners and lessors of premises used to conduct the event, all of which are hereinafter referred to as 'releases', from any liability of each of the undersigned, his/her heirs or next of kind for any against any claim by or on behalf of the applicant as a result of the applicant's participation in the Programs and/or being transported to or from the same, which participation, after careful consideration I hereby authorize, and which transportation I hereby authorize.

I, the parent, or the applicant/participant received a physical examination by a physician and have been found physically capable of participating in the Program. I hereby give my consent to have an athletic trainer, coach, and/or doctor of medicine or dentistry or associated personnel provide the applicant/participant with medical assistance and/or treatment and agree to be financially responsible for the cost of such assistance and/ or treatment. I, also agree to save and hold harmless and indemnify each and all parties herein referred to above as releases from all liability, loss, cost, claim, or damage whatsoever, including death or damage to property, which may be imposed upon said releases because of any defect in/or lack of such capacity to so act or caused or alleged to be caused in whole or in part by the negligence of the releases.

I have read the above waiver/release and understand that (1) we have given up substantial rights by signing this release and signing below voluntarily. I understand that this document may not be altered in any manner and any alteration without the express written consent from Futsoccer International will cause the participant to be removed.

**Date:** _____/_____/_____

**Parent / Guardian - Print Name** _____

**Signature** _____

**Parent / Guardian - Print Name** _____

**Signature** _____

infofutsoccer@gmail.com
info@futsoccer.com
futsoccer.net
(480) 213 8706

# MEDICAL HISTORY AND EXAMINATION FORM

## I. MEDICAL HISTORY

*MEDICAL HISTORY MUST BE COMPLETED BY THE APPLICANT IN ENGLISH AND SIGNED BEFORE VISITING THE EXAMINING PHYSICIAN*

***PLEASE TYPE OR PRINT IN INK***

**Indicate "YES" or "NO". "YES" answers MUST be explained in the space provided. (Additional space is available on Page 2 of this form.)**

| | Yes | No | Explanation |
|---|---|---|---|
| a) Have you ever had any significant or serious illness(es) or injuries? (State nature of problems/places/dates.) | | | |
| b) Have you ever had any operations or been advised by a physician to have an operation? (Describe and give places/dates.) | | | |
| c) Have you ever been a patient in a mental hospital or sanitarium or treated by a psychiatrist? (Give places/dates.) | | | |
| d) Do you currently take medication for treatment of a medical condition (list name/dose) or do you require the use of a medical device? | | | |

**Do you now have or have you ever had any of the conditions listed below? (Check "YES" or "NO" for each Item.)**

| | Yes | No | Check each item | Yes | No |
|---|---|---|---|---|---|
| a) Epilepsy, convulsions, fits. | | | m) Tropical diseases (malaria, bilharzia, amoebiasis, leprosy, filariasis, yaws, etc.). | | |
| b) Eye disease, vision defect in one or both eyes. | | | n) Depression, anxiety, attempted suicide or other psychological symptoms. | | |
| c) Tooth or gum disease (periodontal disease). | | | o) Drug or narcotic habit such as marijuana, cocaine, heroin, LSD, or any derivatives. | | |
| d) Asthma, emphysema, or other lung conditions. | | | p) Drug or narcotic habit such as marijuana, cocaine, heroin, LSD, or any derivatives. | | |
| e) Tuberculosis or exposure to tuberculosis. | | | q) Bleeding disorder. blood disease, sickle cell anemia. | | |
| f) High/low blood pressure, heart disease. | | | r) Tumor, abnormal growth, cyst, or cancer. | | |
| g) Stomach, liver (hepatitis), gallbladder disease. | | | s) Skin disorder growths psoriasis. | | |
| h) Hernia (rupture)/Genito-Urinary/Rectal Disorder. | | | t) Gynecological disease/abnormal menses. | | |
| i) Kidney or bladder condition, stone or blood. | | | u) Hearing impairment. | | |
| j) Diabetes, sugar in the urine. | | | Other: | | |
| k) Joint disease or injury, swollen or painful joints. | | | Other: | | |
| l) Back pain, or spinal condition, use of back brace. | | | Other: | | |

**If you answered YES to any item, please explain in detail (include dates of occurrence, treatment, and outcome:**

_____

_____

_____

_____

_____

# MEDICAL HISTORY AND EXAMINATION FORM

## II. PHYSICAL

*THIS PHYSICAL EXAMINATION FORM MUST BE COMPLETED IN ENGLISH BY A DESIGNATED AND QUALIFIED PHYSICIAN AFTER REVIEWING THE EXAMINEE'S MEDICAL HISTORY (PART I), CONDUCTING A PHYSICAL EXAMINATION, AND ASSESSING LABORATORY AND X-RAY RESULTS. THE EXAMINING PHYSICIAN MUST COMMENT ON ALL POSITIVE AND/OR SIGNIFICANT FINDINGS AND SIGN WHERE INDICATED.*

***PLEASE TYPE OR PRINT IN INK***

1. APPLICANT'S NAME: _____

Last First Other

2. HEIGHT:_____ in or cm

3. WEIGHT:_____ lb or kg

4. CORRECTED VISION: 20:_____ 20:_____

Left Right

5. BLOOD PRESSURE:_____ syst./diast.

6. PULSE RATE:_____ Circle whether regular irregular

7. URINALYSIS: _____ Sugar _____ Albumin _____ Microscopic examination

8. ELECTROCARDIOGRAM REPORT (If indicated by history or physical examination):

9. BLOOD SEROLOGY TEST FOR SYPHILIS: Test Used: Pos Neg

10. A SKIN TEST FOR TUBERCULOSIS IS REQUIRED OF ALL APPLICANTS UNLESS A BCG VACCINATION HAS BEEN GIVEN RECENTLY. If vaccinated and a PPD skin test is contraindicated, a chest X-Ray is required to rule out active tuberculosis.

Tuberculin Skin Test:

PPD Test: _____ Pos Neg

CG Vaccine Given: □ No □ Yes Date of Series: _____

Date and Result of Chest X-Ray: _____

# MEDICAL HISTORY AND EXAMINATION FORM

11. CLINICAL EVALUATION: (Please provide an answer to each item. Abnormal findings must be fully explained in the space provided.)

| | NORMAL | ABNORMAL | DESCRIBE ABNORMAL FINDINGS |
|---|---|---|---|
| (a) Head, Nose, Mouth. | | | |
| (b) Ears, Hearing Acuity. | | | |
| (c) Eyes, Visual Acuity. | | | |
| (d) Lungs and Chest/Breast. | | | |
| (e) Heart, Rhythm and sounds. | | | |
| (f) Vascular System. | | | |
| (g) Abdomen, Hernia, etc. | | | |
| (h) Rectum/Prostate, Hemorrhoids, Fistula. | | | |
| (i) Urinary System. | | | |
| (j) Spine and Extremities. | | | |
| (k) Skin, Lymph Nodes, Scars. | | | |
| (l) Neurological System/Reflexes. | | | |
| (m) Emotional Stability. | | | |

12. THE PHYSICIAN MUST COMMENT ON ALL ITEMS MARKED "YES" IN THE MEDICAL HISTORY (PART I) AND COMMENT ON ANY CONDITION DISCOVERED DURING THE EXAMINATION.

13. PHYSICIAN'S SUMMARY STATEMENT AND DIAGNOSIS:

# MEDICAL HISTORY AND EXAMINATION FORM

## IMMUNIZATION REQUIREMENTS

The applicant is responsible for obtaining the required immunizations for entry into the United States. The WHO International Certificate of Vaccination is the proper document for recording immunizations or vaccinations. Universities require proof of immunization against the following diseases:

MEASLES (Rubeola)
Date of Live Immunization: _____
or Date of Disease: _____

NOTE: HISTORY OF DISEASE IS NOT ACCEPTABLE PROOF OF IMMUNITY TO RUBELLA.
RESULTS:_____

RUBELLA
Date of Immunization: _____
or Date of Rubella Titer: _____

POLIO
Date series completed, type: _____

MUMPS
Date of Immunization: _____

DIPHTHERIA (DPT), Whooping Cough, Tetanus
Date series completed: _____

TETANUS BOOSTER (Most Recent): _____

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**Emergency Contact: Name two individuals who could be notified in case of an emergency (one in the United States and one in your home country)**

**Name:**_____ **Address:** _____ **Name:**_____ **Address:** _____
**Phone:**_____ **Relationship:**_____ **Phone:**_____ **Relationship:**_____

**I certify that I reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. In the event of a serious illness or medical emergency during the grant activity, I authorize the release of my medical records to the United States Department of State or its designated contractual agency.**

**I understand that any of this information is found to be substantially inaccurate or incomplete, it may be grounds for termination of my grant and my return home.**

**Signature:**_____ **Date:** _____/_____/_____