

# BARROW YOUTH SOCCER ASSOCIATION MEDICAL WAIVER

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Name of Child: \_\_\_\_\_  
Last First M.I.

Date of Birth: \_\_\_\_\_ Grade in School: \_\_\_\_\_

**Parent's Statement:**

I certify that my child is medically qualified to participate in the Barrow Youth Soccer Association program. I hereby authorize Barrow Youth Soccer Association and Barrow County Leisure Services to act for me according to their best judgment in securing treatment for my child in any emergency requiring medical attention.

**Medical History:**

Yes	No	(Check One)	If answered yes, please specify
_____	_____		Contact or glasses? _____
_____	_____		Dental Appliances? _____
_____	_____		Asthma (medication)? _____
_____	_____		Convulsions, seizures (medication)? _____
_____	_____		Heart Murmur, high blood pressure, any heart abnormalities? _____
_____	_____		_____
_____	_____		Congenital absence or loss of function of one organ (eye, ear, kidney, etc.)? _____
_____	_____		Neck or Spine injury? _____
_____	_____		Broken Bones? _____
_____	_____		Sprains or dislocations? _____
_____	_____		Medicine Allergies? _____
_____	_____		Diabetes? _____
_____	_____		Any current injuries? _____
_____	_____		Currently taking medication(s)? _____

Preferred Hospital \_\_\_\_\_

Physician \_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_

Parent/Guardian Signature