

# Loudoun Soccer

P.O. Box 1358, Leesburg, VA 20177 Phone: 703-777-9977 www.loudounsoccer.com

**TOPSoccer** Program Registration Form – Fall 2010  
Location: Ida Lee Park or Simpson Middle School in Leesburg

## Player Information

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ **Proof of age required.**

Total number of seasons played: \_\_\_\_\_ Returning Loudoun Soccer Player Yes No

## Parent/Guardian Information

Parent(s)/Guardian(s): \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone # \_\_\_\_\_

Office Phone # \_\_\_\_\_

Cellular Phone # \_\_\_\_\_ Cellular Phone # \_\_\_\_\_

E-Mail: \_\_\_\_\_

E-Mail: \_\_\_\_\_

## Emergency Information

Person to contact in case of emergency: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone # \_\_\_\_\_

Office Phone # \_\_\_\_\_ Cellular Phone # \_\_\_\_\_

Fall 2010 Registration Fee - \$35.00  
(\$25.00+\$10 Loudoun Co. Usage fee per player)  
Please make checks payable to Loudoun Soccer

DO NOT WRITE BELOW

LOUDOUN SOCCER USE ONLY

DO NOT WRITE BELOW

Postmark CC \_\_\_\_\_ Check# \_\_\_\_\_ Amount\$ \_\_\_\_\_ Registered BY \_\_\_\_\_ Entered By \_\_\_\_\_ Proof of Age \_\_\_\_\_



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## ATHLETE'S APPLICATION/AGREEMENT TO PARTICIPATE

I, \_\_\_\_\_, wish to participate in youth soccer, and more particularly in the \_\_\_\_\_ TOPSoccer Program. In connection with my participation, I acknowledge the risk of possible physical harm to me as a result of my participation and that the risk of harm may be increased because of my (name(s) of disability(ies) \_\_\_\_\_ and for which I have received or am receiving medical attention.

While there is no immediate danger to me, I am told that strenuous, collision type activities, such as soccer, could render me more susceptible to future problems due to my disability(ies) than might normally be expected. I have discussed this situation with my parent(s)/guardian(s) and we understand the potential danger of participating in soccer.

Notwithstanding that my participation in youth soccer may constitute more risk to me than it does to other athletes, I nevertheless wish to participate in youth soccer. In making this decision, I am aware of the value of participating in youth sports programs in my life, and choose to participate in order to take full advantage of those values. In weighing the risk to myself of potential injury now and in the future, I wish to exonerate and save harmless the \_\_\_\_\_ TOPSoccer Program, its sponsoring club/association, and the Virginia Youth Soccer Association and the agents, servants and employees of those organizations, from any liability as a result of an injury or death relating to my disability(ies) and not to any injury that may occur in the future which is unrelated to my disability(ies). I execute this agreement freely, fully intending to be bound by same.

\_\_\_\_\_  
Participant Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

## PARENTAL CONSENT FOR TOPSOCCER PARTICIPATION

I am the parent/legal guardian of \_\_\_\_\_ and on whose behalf I have submitted the attached Athletes Application/Agreement to Participate in the Loudoun Youth Soccer Association TOPSoccer Program.

I hereby declare and warrant that to the best of my knowledge and belief that he/she is both physically and mentally able to participate in TOPSoccer. With my approval, a licensed physician has certified that, based on an independent medical examination, there is no medical evidence that would preclude his/her participation in TOPSoccer. I also understand that if he/she has been diagnosed to have Down Syndrome, a radiological examination for the purpose of determining the presence or absence of atlantoaxial instability is required for his/her participation in TOPSoccer.

I further understand that my presence or the presence of my spouse or other legal guardian is required at all Loudoun Soccer TOPSoccer and Virginia Youth Soccer Association (VYSA) TOPSoccer Program events, including but not limited to practices, games, festivals, etc. in which he/she participates. I clearly understand that the reason for the required presence of a parent or guardian for TOPSoccer activities is based in part on issues surrounding emergency care should it be needed.

In permitting my son/daughter to participate in the Loudoun Soccer TOPSoccer Program, I specifically grant my permission for TOPSoccer to use his/her likeness, name, voice, and/or words in television, radio, film, newspaper, magazine, and/or other media for the purpose of informational outreach for TOPSoccer and/or seeking funds and other types of support for TOPSoccer.

As the parent/legal guardian of \_\_\_\_\_, I have read and understand fully each of the above provisions. Through my signature on this consent form, I acknowledge and agree with each of the above provisions on my own behalf and that of my participating child. I also recognize the potential risk(s) that are involved with my child's participation in TOPSoccer and agree to hold harmless the TOPSoccer coaches, volunteers, and others involved in administering this program should harm relating to his/her disability(ies) occur to my child when he/she is participating in TOPSoccer.

I hereby declare that \_\_\_\_\_ has my permission to participate in TOPSoccer.

**Signature of Parent or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

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## Medical Certification Form for TOPSoccer Participation

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

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

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

Sex: M \_\_\_ F \_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

\_\_\_\_\_

- Note to the Physician – If this child has Down Syndrome, TOPSoccer requires that, in order to participate in TOPSoccer, he/she has a complete radiological examination for the purpose of establishing the absence of atlantoaxial instability.

\_\_\_\_\_

### **Physician Statement/Information:**

Physician's Name: \_\_\_\_\_ Office Phone # \_\_\_\_\_

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

Physician's Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*"I have reviewed the above player's health information and examined the player and certify that there is no medical evidence apparent to me that would preclude him/her from participating in TOPSoccer"*

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Atlanto-axial Instability Certification

Important Note: **If your child has Down Syndrome, he/she must have a complete radiological examination for the purpose of establishing the absence of atlanto-axial instability.**

### *Player Information*

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

Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### *Parent/Guardian Information*

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

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

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

### Physician Statement/Information

Family Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City, State: \_\_\_\_\_

Physician's Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

"I have reviewed the above player's health information, examined the player, and certify that there is no medical evidence apparent to me that would preclude him/her from participating in TOPSoccer."

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_