

Child Name: _____ Sex: M F Birth date: _____

Section III: _____

Summary of Significant Treatment Program Including Names/Doses of Medications to be used while at program:
(Medications **MUST** be in a container with the original label)

Section IV: Immunizations

Immunization	Date	Immunizations	Dates
Has completed primary series of tetanus/diphtheria? (Four Does) Yes___ No___			
Completed primary series of polio immunizations? Yes___ No___			
Primary Series- Type of vaccine: OPV IPV E-IPV ___/___/____. Last Booster Type of vaccine: OPV IPV E-IPV ___/___/____.			
Must be within last ten years (Complete only if primary series was more than ten years ago.):	Month/Day/Year ___/___/___	Mumps or MMR #1 Must be AFTER age 12 Months: OR Positvie Mumps Titer (blood test):	Month/ Day/ Year ___/___/____ Month/ Day/ Year ___/___/____
Measles #1 (Rubeola, Red Measles)-Must be AFTER age 12 Months: OR MMR #1: OR Postive Measles Titer (blood test):	Month/ Day/ Year ___/___/____ Month/ Day/ Year ___/___/____ Month/ Day/ Year ___/___/____	Rubella or MMR #1 (German Measles)- Must be AFTER age 12 Months: OR Postive Mumps Titer (blood test):	Month/ Day/ Year ___/___/____ Month/ Day/ Year ___/___/____
Measles #2 (Rubeola, Red Measles)- Most Be at least 30 Days AFTER First dose: OR MMR #2:	Month/ Day/ Year ___/___/____ Month/ Day/ Year ___/___/____	Hepatitis B Those born AFTER 1-1-92 Dose #1 Dose #2 Dose #3	Month/ Day/ Year ___/___/____ ___/___/____ ___/___/____

Medical Exemption: The above named person does not have one or more of the required immunizations because he/she has a medical problem that precludes the _____ vaccine(s)

Health Care Provider Signature and/or stamps: _____ Date: _____

Printed Names: _____

Address: _____ Telephone #: _____

Return form to Program

Participant Name:(print) _____
(Last) (First) (MI)

**MEDICAL AND IMMUNIZATION HISTORY
PROGRAM AND CAMPS**

Section I: (To be completed by Parent or Gaurdian) _____

Name: _____ Sex: M F Birthdate (Month/Date/Year): _____

Address: _____ City: _____ State: _____ Zip: _____

Program Name: _____ Program Dates: _____ to _____ Soc. Sec: _____ - _____ - _____

Father: _____ Telephone (Day): _____ Telephone (Evening) _____

Mother: _____ Telephone (Day): _____ Telephone (Evening) _____

Guardian is: Father: _____ Mother: _____ Other (Name & Address): _____
Telephone Number: _____

In case of illness or emergency the name and telephone number of a person to contact: (Relation to participant) _____

Family Physician or HMO (Name & Address): _____
Family Physician or HMO Telephone Number: _____

Family Dentist (Name & Address): _____
Family Dentist Telephone Number: _____

Medical Insurance Company Name: _____ Policy Number: _____

In case of medical emergency, I hereby give permission to the University Health Service staff to hospitalize, to secure proper treatment for, and to order injection or minor sugery for my child, as named above.

Date: _____ Parent/ Guardian Signature: _____

Section II:

Physical Examination: (Must be in the preceeding 12 months and done by Medical Provider)

Medical History: (Please note significant disorders)

Allergies: _____	Heart: _____	Turberculosis: _____
Allergies: _____	Kidney: _____	Whooping Cough: _____
Diabetes: _____	Lung: _____	Varicella: _____
Disabilities: _____	Neurological: _____	Other: _____

Medical History: _____

MASSACHUSETTS SOCCER ACADEMY

LIABILITY WAIVER

The undersigned and undersigned's heirs, executors and administrators, hereby waive and forever release and discharge Massachusetts Soccer Academy, its officers, directors, employees, agents successors and assign of and from any and all claims, suits or rights for damages for personal property damage or physical injury which may be sustained or which occurs during participation in activities or that may occur to or from said activity, whether or not such injuries or property damage or loss is caused by is connected to or arises out of any acts or omissions or the negligence of Massachusetts Soccer Academy, its officers, directors, employees, agents, successors or assigns or of the school at which the activity is held.

Parent/Guardian Name: _____

Signature: _____

Date: _____

PHOTOGRAPH AND VIDEO AUTHORIZATION

I agree that photographs and or video tapes in any form or medium of my child, may be taken or used by Massachusetts Soccer Academy for any reason, including, but not limited to, public relations, advertising, sales, etc.. And agree that such materials shall become the sole and exclusive property of Massachusetts Soccer Academy and further agree to give up all rights, title and interest in such property, and I hereby release and discharge Massachusetts Soccer Academy, its officers, directors, employees, agents, successors and assign from and against all claims, etc. Arising out of or in connection with the creation of, title to use and or distribution of such materials by Massachusetts Soccer Academy, its successors, agents.

Parent/Guardian Name: _____

Signature: _____

Date: _____

MEDICAL TREATMENT AUTHORIZATION

I hereby authorize medical treatment and care for my son, that may include routine diagnostic procedures (i.e., physical examination, x-rays, blood and urine tests) and medical treatment as may be necessary. I understand that the consent and authorization granted herein does not include surgical procedure are valid only during the time that my son is in attendance (if your son has any physical condition or requires any treatment or medication that a clinician should be aware of (i.e., allergies, disabilities, etc.) you must provide written notification to Massachusetts Soccer Academy at or before registration. In the event that an illness or injury requires extensive evaluation, I understand that every reasonable attempt will be made to contact me. However, in the event of an emergency and if I can not be reached, I give my consent for my son to receive the proper treatment and or medical services needed to be perform any necessary emergency procedures.

Parent/Guardian Name: _____

Signature: _____

Date: _____