Vernon Soccer Club

PLAYER PARTICIPANT WAIVER

VSC P.O. Box 2295 Vernon, CT 06066

Parent or Guardian 1:

First Name_____ Last Name_____ Relationship to Player_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Mobile Phone_____ Email_____

Parent or Guardian 2:

First Name_____ Last Name_____ Relationship to Player_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Mobile Phone_____ Email_____

Participant:

First Name_____ Last Name_____ Relationship to Player_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Mobile Phone_____ Email_____

Gender_____ Birthdate mm/dd/yyyy_____ Country of Birth_____

Citizenship_____ Has the player played this sport while living outside the US? Yes/No

Emergency Contact & Medical Information
In an emergency when parents cannot be reached, please contact:

Emergency Contact First Name_____ Emergency Contact Last Name_____

Emergency Contact Primary Phone _____ Secondary Phone_____

Emergency Contact 2 First Name_____ Emergency Contact 2 Last Name_____

Emergency Contact 2 Primary Phone_____ Secondary Phone_____

Allergies_____ Other Medical Conditions_____

Player's Physician_____ Physician Phone_____

Medical and/or Hospital Insurance Company_____ Insurance Company Phone_____

Policy Holder_____ Policy #_____ Group #_____

Injury Waiver:
Recognizing the possibility of physical injury associated with soccer and in consideration for the Vernon Soccer Club and its affiliates accepting the registrant for its soccer programs and activities (the "Programs"), I hereby release, discharge and/or otherwise indemnify the Vernon Soccer Club, its affiliated organizations and sponsors, their employees and associated personnel, including the owner of fields and facilities utilized for the Programs against any claim by or on behalf of the registrant as a result of the registrant's participation in the Programs and/or being transported to or from the same, which transportation I hereby authorize. Consent for Medical Treatment: As parent or legal guardian of the above named player, I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Dentistry. This care may be given under whatever conditions are necessary to preserve life limb, or well-being of my dependent.

Image and Likeness Waiver:
I hereby give my permission to Vernon Soccer Club, Incorporated, hereafter known as VSC, to use photographs of the above listed minor in any publication, media release, promotional announcement or advertisement, electronic or otherwise. I agree that neither the above listed minor, nor I, will receive any compensation if such image appears in such publication, media release, promotional announcement or advertisement, electronic or otherwise. I understand that such image is the property of VSC. In addition, I understand that VSC may supply such images to, or for the use and publication by, a corporate sponsor or licensee of VSC in or for any commercial venture or advertisement, without my permission, if the use or publication is directly related to or in support of VSC.

Concussion Information and Waiver:
All Vernon Soccer Club athletes and parents must read and acknowledge this waiver before the start of the season to be permitted to participate in VSC activities.

1. As a player I understand that it is my responsibility to report all injuries to my coach to let him or her know of any precautions they must take. If at all possible, I will undergo a baseline concussion test prior to the start of the season.
2. I understand that a concussion is a Traumatic Brain Injury and the effects and implications of any such injury are severe. Some symptoms of a concussion are forgetfulness, nausea, headache or pressure, blurry vision, clumsiness, and confusion. For severe concussions, loss of consciousness may occur.
3. A concussion may affect my ability to perform everyday tasks and may affect reaction time, sleep patterns, balance, and cognitive performance. For more information on concussion symptoms:
http://www.cdc.gov/concussion/sports/recognize.html
4. A concussion can have symptoms that show up a few hours after the initial injury and all head injuries should be treated with caution, therefore a player who has had any kind of head trauma must be monitored even if symptoms only showed for 15 minutes. In rare cases, repeat concussions can cause permanent brain damage and even death.
5. As a player, I understand it is my responsibility to report any symptoms or problems to my coach and / or parents in a timely manner.
6. I will not return to play in a game or practice if I have received a blow to the head that has resulted in concussion-related symptoms. I understand that this is a precautionary measure to prevent any further injury until a proper diagnosis is received by a qualified medical professional.
7. If I am experiencing concussion-related symptoms as reported by me and confirmed by the coach, I must seek medical attention from a qualified professional before I will be allowed to return to play. Physical and mental rest is the only treatment for concussions and even mild concussions require at least a week of rest to fully heal. The CDC recommends a gradual 6-step progression back into sport participation, which should be implemented and monitored by a medical professional. The 6-step return to play progression is outlined here:
http://www.cdc.gov/concussion/headsup/return_to_play.html
8. I must get cleared by a medical professional trained and experienced in diagnosing and treating concussions before being allowed to return to physical activity. Written confirmation of this clearance must be provided to VSC.
9. I have read the Concussion Fact Sheet located here:
http://files.LeagueAthletics.com/Images/Club/15056/HeadsUpConcussion.pdf

Parent or Guardian Printed Name:_____

Signature_____ Date____/_____/_____