



**Indiana Youth Soccer Association
Coach Health Report**

(To be completed and submitted upon check-in)

THIS FORM DOES NOT NEED TO BE COMPLETED BY PHYSICIAN

Name _____ Date of Birth _____

Home Address _____ City _____

State _____ Zip _____ Home Phone _____

Family Physician _____

Office Phone _____

PLEASE ANSWER EVERY QUESTION ABOUT YOUR HEALTH:

- | | | |
|-----|---|----------------|
| 1. | Has had any injuries requiring medical attention | Yes ___ No ___ |
| 2. | Has had illness lasting more than one week. | Yes ___ No ___ |
| 3. | Is under a physician's care now. | Yes ___ No ___ |
| 4. | Takes medication now. | Yes ___ No ___ |
| 5. | Wears glasses ___ Wears contact lenses ___ | Yes ___ No ___ |
| 6. | Has had a surgical operation | Yes ___ No ___ |
| 7. | Has been in hospital (except for tonsillectomy) | Yes ___ No ___ |
| 8. | Has high blood pressure, abnormal heart rate or any heart disease | Yes ___ No ___ |
| 9. | Has had trouble with dehydration (except loss of salt water). | Yes ___ No ___ |
| 10. | Has had heat stroke. | Yes ___ No ___ |
| 11. | Has any known drug, food, or pollen allergy. | Yes ___ No ___ |
| 12. | Has been immunized against flu ___ polio ___ tetanus ___ | Yes ___ No ___ |
| 13. | Should not participate in strenuous exercise. | Yes ___ No ___ |

PLEASE EXPLAIN ANY YES ANSWERS TO ANY OF THE QUESTIONS:

(YOU MUST COMPLETE BOTH SIDES OF FORM IN ORDER TO ATTEND COURSE)



RELEASE OF LIABILITY

NAME (PRINT) _____ MALE _____ FEMALE _____

ADDRESS _____

CITY & STATE _____

PHONE # _____ DATE OF BIRTH _____

EMERGENCY CONTACT AND NUMBER _____

Being fully cognizant of the physical training requirements of the Indiana Youth Soccer Association Coaching Education Program, I represent that I am physically able to participate and hereby hold the IYSA, their coaching staff, and each of their administrators harmless for any injury or medical problem that might occur. I assume the risk of injury or medical problem, and I release and waive any claim that might be made by me or my heirs upon the aforesaid.

Signature _____

Date _____