



CALIFORNIA YOUTH SOCCER ASSOCIATION

STATE "D" COURSE

Location: Franklin High School (6400 Whitelock Parkway, Elk Grove, CA 95757) and Underwood Park
Course Date: June 19, 20, 21 and 26, 27, 28
Course Contact: Linda Padilla, CYSA District VI Director of Coaching
Address: 705-2 East Bidwell Street, #367 Folsom, CA 95630
Phone #: 916-342-0381 **Email:** Padilla.consulting@sbcglobal.net
Course Fee: **\$350.00** Payable to: CYSA District VI

Prerequisites: CYSA E/D License (may be taken in the same year).

Course Requirement: Attending a Referee License Course (grade 8)- before or after the National D course.

Send in with this application form, copies of both documents, and your non-refundable fee of **\$350.00**. If you do not have a referee license by the time of the course, you may still take the course, but you will not receive your D license certificate until you submit proof of attending a referee course.

Mail required documents and deposit to: Course Contact listed above. **ONLY APPLICATIONS MAILED IN WITH ALL 3 PAGES AND A CHECK FOR \$350 PAYABLE TO: CYSA District VI WILL BE CONSIDERED.** Please **include a copy of your VALID CYSA E/D license** and Referee license if you already have one. Once your valid documentation has been reviewed, you will be informed if you have been accepted into the course.

ENROLLMENT IS LIMITED TO THE FIRST 15 QUALIFIED CANDIDATES

Name: _____

Address: _____

City: _____ St: _____ Zip: _____

Phone: () _____ Cell Phone: () _____

Fax: () _____ DOB: (for database): _____

E-Mail: _____

District # _____ League # _____ Gender: (please circle): M F

Verification of acceptance will be mailed to all candidates upon receipt of this application, copies of all prerequisite documents and the \$275.00/ \$350.00 Fee. Please contact Karl Dewazien for additional details and questions: 559-447-1869.

- **Course Contact: Please attach all back up documentation for each candidate to their application when submitting to the CYSA Office.**

MEDICAL HISTORY QUESTIONNAIRE

LAST NAME _____ FIRST NAME _____ MIDDLE I. _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ - _____ - _____ GENDER M _____ F _____

EMERGENCY CONTACT: _____

HM PH (____) _____ WK PH (____) _____ CELL: (____) _____

PLEASE CIRCLE "NO" OR "YES" AND PROVIDE ADDITIONAL DETAILS WHERE REQUESTED ON BOTH SIDES OF THIS FORM. ALL INFORMATION WILL BE CONFIDENTIAL.

1. Are you allergic to any medication (aspirin, penicillin, sulfa, etc)? **NO YES** (list) _____
2. Do you take any prescribed medication on a permanent or semi-permanent basis (steroids, birth control pills, Anti-inflammatories, antibiotics, etc.)? **NO YES** (List and give reason) _____
3. Have you ever had an epileptic seizure? **NO YES**
4. Have you ever been told by a doctor that you have epilepsy? **NO YES** (List medication) _____
5. Have you ever been treated for diabetes? **NO YES**
6. Have you ever been told by a doctor that you were anemic **NO YES** When? _____
9. Do you or have you ever had high blood pressure? **NO YES** (List medication) _____
10. Do you or have you ever had the following diseases?
NO YES (give date) _____ heart disease (heart murmur, rheumatic fever)
NO YES (give date) _____ lung disease (pneumonia)
NO YES (give date) _____ kidney disease (infectious)
NO YES (give date) _____ liver disease (mononucleosis, hepatitis)
11. Do you or have you ever been told by a doctor that you have asthma? **NO YES** (list medication) _____
12. Do you or have you ever had a hernia or "rupture"? **NO YES** Has it been repaired _____ Date _____
13. Have you ever been "knocked out" (unconscious) in the past 3 years? **NO YES** (list dates) _____
14. Have you had a concussion or other head injury in the past 3 years? **NO YES** (list dates) _____
15. Have you stayed overnight in a hospital due to a head injury? **NO YES** (list dates) _____
16. Have you ever had a neck injury involving bones, nerves or disks that disables you for a week or longer
NO YES Type of injury _____ Dates _____
17. Do you wear glasses or contacts during competition? **NO YES**
18. Do you wear any of the following dental appliances: PERMANENT BRIDGE, BRACES, REMOVABLE RETAINER, PERMANENT RETAINER, REMOVABLE PARTIAL PLATE, FULL PLATE, PERMANENT CROWN OR JACKET?
NO YES (circle those which apply)
19. Have you had a broken bone or fracture in the past 2 years? **NO YES** R _____ or L _____
What bone(s) _____ Dates _____
20. Have you ever had a shoulder injury in the past 2 years that disabled you for a week or longer? (dislocation, Separation, etc) **NO YES** R _____ or L _____ Type of injury _____ Date _____
21. Have you ever had shoulder surgery? **NO YES** R _____ or L _____ What was done & why? _____ Date _____
22. Have you ever injured your back? **NO YES** Type of Injury _____ Date _____
23. Do you have back pain? **NO YES** (circle those that apply) SELDOM, OCCASIONALLY, FREQUENTLY, WITH VIGOROUS EXERCISE, WITH HEAVY LIFTING
24. Have you injured your knee in the past two years? **NO YES**
25. Have you been told by a doctor or athletic trainer that you injured the cartilage in your knee? **NO YES** R _____ or L _____
Date _____
26. Have you been told by a doctor or athletic trainer that you injured the ligaments in your knee? **NO YES** R _____ or L _____
Date _____
27. Have you ever had knee surgery? **NO YES** R _____ or L _____ What was done? _____ Date _____
28. Have you had a severe ankle sprain in the past 2 years? **NO YES** R _____ or L _____
29. Do you have a pin, screw, or plate in your body? **NO YES** Where in your body? _____ Date _____
30. Do you have other conditions that we should be aware of (i.e ulcers, pregnancy, food or insect allergies, tendinitis, etc.)?
NO YES (specify and give details) _____
31. **DATE OF YOUR LAST** Tetanus shot: _____

THE QUESTIONS ON THIS FORM HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE:

Candidates Name: _____ Signature _____ Date _____



Coaching Program Medical Release Treatment Form State "D" Candidates

I hereby give my consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Dentistry for:

_____ (LAST NAME, FIRST NAME) as it appears on Birth certificate-NO NICK NAMES

This care may be given under whatever conditions are necessary to preserve life, limb or well being of myself. I also hereby release the California Youth Soccer Association, Inc. and affiliated organizations and personnel, owners of fields and facilities used by the California Youth Soccer Association against any claim by or on behalf of registrant as a result of the registrant's participation in the Program, and/or being transported to and from, which transportation I hereby authorize.

Print Name

Signature

Date

PLEASE PRINT LEGIBLE, THIS IS IMPORTANT INFORMATION

CANDIDATE INFORMATION			
Name:	M	F	Date of BIRTH :
Address:	City:		Zip:
Home Phone:	Cell Phone:		
Medical Insurance carrier:			
Medical Card Number: (Do not send a copy of card)			
EMERGENCY CONTACT INFORMATION			
<i>Please complete the following with contact information of a person that can be reached while you are attending the course.</i>			
Name:		Relationship to you:	
Work Number:		Home Number:	
Cell Number:		Alternate number:	
Alternate Contact:		Work Number:	
Home Number:		Cell Number:	