Costa Blanca Cup

INTERNATIONAL YOUTH SOCCER TOURNAMENT
BENIDORM, SPAIN

TRAVELING DOCUMENTS

FOR PARENTS:

1. PASSPORT original and copy
2. VISA – not required for US citizens
3. Authorization for travel outside the US with a Minor
4. Emergency Medical Release & Liability Waiver
5. Emergency Contact Information
6. Medical History and Examination
7. Traveling Insurance

EMERGENCY CONTACT INFORMATION

Traveler Information:

1. First Name _____ Last Name _____

   Date of Birthday: _____ Passport :_____

2. First Name _____ Last Name _____

   Date of Birthday: _____ Passport :_____

3. First Name _____ Last Name _____

   Date of Birthday: _____ Passport :_____

4. First Name _____ Last Name _____

   Date of Birthday: _____ Passport :_____

5. First Name _____ Last Name _____

   Date of Birthday: _____ Passport :_____

Emergency Contact Name:

Contact Name_____ Phone: _____

Traveler Emails: _____

Primary Phone: _____ Cellular: _____

Country: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip/Postal: _____

Comments Text:

_____ _____ _____

Print Name Signature Date

2016 Trip to Spain
Luggage Suggestion and Documents required

Soccer Gear:

Deflated Soccer Ball (1), Shorts (4), Soccer Socks (4), Cleats (1), Shin Guards (1), Tennis shoes (1), Team Uniform, warm ups (2) – If the player has soccer turf shoes please bring it.

Clothing:

Shirts (8), under wear (8), Socks (8), Shorts (4), Sweater (1), Jeans (1), Jacket (1)

Soap (1), Shampoo (small), tooth / paste / Brush (1), Sun Block (1), Insect Repellent off (1)

Sport Hat (1), Sandals (1), water bottle and Plastic bags

Traveling Documents:

Original Passport and (1) copy "Photo page"

Authorization for Travel outside the United States of a Minor

Authorization and Consent for Emergency Medical release

Medical History and Examination: If the player is taking any medicine

*Please inform and advise in writing, attached to medical history document, In case of allergy or intolerance to any type of medicine. In the case of continuous drug use lead to medical prescription with international regulations.

AUTHORIZATION FOR TRAVEL OUTSIDE THE UNITED STATES, Of A MINOR

To Whom It May Concern:

This letter is in relation to my/our child, _____ [name of child], who is a citizen of the United States of America and a minor born on _____ [specify child's date of birth]. My/our child holds a U.S. passport with the number _____.

I/we do solemnly swear that I/we have legal custody of my/our child and that no pending divorce or child custody proceedings involving my child exist. I/we do hereby grant full authorization and consent for my/our child to travel outside of the United States with _____ [specify name of adult with whom child will travel], who is the _____ [specify adult's relationship with child] of my child. The purpose of the travel is _____ [specify vacation, touring, to visit relatives, to accompany adult on business trip or other reason]. I/we have approved the following travel plans:

Dates of travel: Destinations/Accommodations:

_____ _____

_____ _____

I/we authorize _____ [name of adult with whom child will travel] to make any changes whatsoever to the travel plans specified above. Under penalty of perjury under the laws of the state of _____, I/we attest to the truthfulness, accuracy, and validity of the forgoing statement.

_____ _____

Signature of Parent #1 Date

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____

Email:_____

_____ _____

Signature of Parent #2 **Date**

Name: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email:_____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

STATE OF_____

COUNTY OF_____

This document was acknowledged before me on_____ [date] by name of principal].

[Notary Seal, if any]:

_____

(Signature of Notarial Officer)

_____

Notary Public for the State of

_____

My commission expires:

Emergency Medical Release & Liability Waiver

Participant's Name_____
Birthdate_____
Street Address _____City
_____ Zip_____

EMERGENCY INFORMATION

Father's Name_____ Home Phone (_____)_____
Cell/Bus Phone (_____)_____
Mother's Name _____ Home Phone (_____)_____
Cell/Bus Phone (_____)_____

In an emergency when parent/guardian cannot be reached or is not applicable, please contact the following:

*Name*_____ Home Phone (_____)_____
Cell/Bus Phone (_____)_____
*Name*_____ Home Phone (_____)_____ Cell/Bus Phone (_____)_____
Allergies_____
_____
Other Medical Conditions_____
_____
Physician_____ Cell Phone (_____)_____ Bus Phone (_____)_____
Medical/Hospital Insurance Company_____ Phone (_____)_____
Policy Holder's Name_____ Policy Number_____

THIS AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT MUST BE COMPLETED BEFORE PARTICIPANT (PLAYER/COACH/REFEREE) CAN PARTICIPATE IN ACTIVITIES. TREATMENT FOR INJURY WILL BE BASED ON INFORMATION PROVIDED HEREIN.

I the undersigned participant and parent/guardian of the above listed minor (if participant is under the age of 18) acknowledge and fully understand that each participant will be engaging in activities that involve risk of serious injury, including permanent disability or death, and severe social and economic losses which might result not only from their own actions, inactions or negligence, but action, inaction or negligence of others, the rules of play, or the condition of the premises or of any equipment used and further, that there may be other unknown risks not reasonably foreseeable at this time, assume all the foregoing risk and accept personal responsibility for the damages following such injury, permanent disability or death, hereby release, discharge, covenants to indemnify and not to sue Illinois Youth Soccer Association, its directors, officers, employees, coaches, managers, agents, sponsors and associated personnel including those of its affiliated organizations, and the owners and lessors of premises used to conduct the event, all of which are hereinafter referred to as 'releasees', from any and all liability to each of the undersigned, his/her heirs or next of kin for any and all against any claim by or on behalf of the applicant as a result of the applicant's participation in the Programs and/or being transported to or from the same, which participation, after careful consideration I hereby authorize, and which transportation I hereby authorize. The applicant/participant has received a physical examination by a physician and has been found physically capable of participating in the Programs. I hereby give my consent to have an athletic trainer, coach and/or doctor of medicine or dentistry or associated personnel to provide the applicant/participant with medical assistance and/or treatment and agree to be financially responsible for the cost of such assistance and/or treatment. I, also agree to save and hold harmless and indemnify each and all parties herein referred to above as releases from all liability, loss, cost, claim or damage whatsoever, including death or damage to property, which may be imposed upon said releases because of any defect in or lack of such capacity to so act or caused or alleged to be caused in whole or in part by the negligence of the releases. I have read the above waiver/release and understand that (I) we have given up substantial rights by signing this release and sign below voluntarily. I understand that this document may not be altered in any manner and that any alternation without the express written consent from the Illinois Youth Soccer Association will cause the participant to be removed from the Program. (revised 7/14/06)

Parents/Guardians Signature_____
Date_____
(Parents/Guardians' Signature is required if participant is under the age of 18)
Participant's Signature_____
Date_____
(Participant's Signature is required)

MEDICAL HISTORY AND EXAMINATION FORM

I. MEDICAL HISTORY

MEDICAL HISTORY MUST BE COMPLETED BY THE APPLICANT IN ENGLISH AND SIGNED BEFORE VISITING THE EXAMINING PHYSICIAN

PLEASE TYPE OR PRINT IN INK

1. NAME: _____
Last *First* *Other*

2. DATE OF BIRTH: _____
Month/Day/Year

3. SEX: ☐ Male ☐ Female

4. PLACE OF ORIGIN OR PERMANENT RESIDENCE: _____
City *Country*

5. PRESENT ADDRESS: _____
Home or Residence *City* *Country*

6. GRANT LOCATION: _____
(If known) *University/City/State*

7. DATES: _____
From *To*

8. Indicate ìYESî or ìNOî. ìYESî answers MUST be explained In the space provided. (Additional space available on Page 2 of this form.)

	YES	NO	EXPLANATION
(a) Have you ever had any significant or serious illness(es) or injuries? (State nature of problems/places/dates.)			
(b) Have you ever had any operations or been advised by a physician to have an operation? (Describe and give places/dates.)			
(c) Have you ever been a patient in a mental hospital or sanitarium or treated by a psychiatrist? (Give places/dates.)			
(d) Do you currently take medication for treatment of a medical condition (list name/dose) or do you require the use of a medical device?			

9. Do you now have or have you ever had any of the conditions listed below? (Check ìYESî or ìNOî for each Item.)

CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO
(a) Epilepsy, convulsions, fits.			(m) Tropical diseases (malaria, bilharzia, amoebiasis, leprosy, filariasis, yaws, etc.).		
(b) Eye disease, vision defect in one or both eyes.					
(c) Tooth or gum disease (periodontal disease).			(n) Depression, anxiety, attempted suicide or other psychological symptoms.		
(d) Asthma, emphysema, or other lung conditions.					
(e) Tuberculosis or exposure to tuberculosis.			(o) Drug or narcotic habit such as marijuana, cocaine, heroin, LSD, or any derivatives.		
(f) High/low blood pressure, heart disease.					
(g) Stomach, liver (hepatitis), gallbladder disease.			(p) Bleeding disorder. blood disease, sickle cell anemia.		
(h) Hernia (rupture)/Genito-Urinary/Rectal Disorder.			(q) Tumor, abnormal growth, cyst, or cancer.		
(i) Kidney or bladder condition, stone or blood.			(r) Skin disorder growths psoriasis.		
(j) Diabetes, sugar in the urine.			(s) Gynecological disease/abnormal menses.		
(k) Joint disease or injury, swollen or painful joints.			(t) Hearing impairment.		
(l) Back pain, or spinal condition, use of back brace.					

10. If you answered ìYESî to any item in Question 9, please explain in detail (include dates of occurrence, treatment, and outcome):

MEDICAL HISTORY AND EXAMINATION FORM

Questions 8 and/or 10 (Continued):

11. Name two individuals who could be notified in case of emergency (one in the United States and one in your home country).

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Telephone number(s): _____ Telephone number(s): _____

Relationship: _____ Relationship: _____

12. I certify that I have reviewed the foregoing information supplied by me, and that it is true and complete to the best of my knowledge. In the event of a serious illness or medical emergency during the grant activity, I authorize release of my medical records to the United States Department of State or its designated contractual agency.

I understand that if any of this information is found to be substantially inaccurate or incomplete, it may be grounds for termination of my grant and my return home.

SIGNATURE: _____ DATE: _____

MEDICAL HISTORY AND EXAMINATION FORM

II. PHYSICAL EXAMINATION FORM

THIS PHYSICAL EXAMINATION FORM MUST BE COMPLETED IN ENGLISH BY A DESIGNATED AND QUALIFIED PHYSICIAN AFTER REVIEWING THE EXAMINEEIS MEDICAL HISTORY (PART I), CONDUCTING A PHYSICAL EXAMINATION, AND ASSESSING LABORATORY AND X-RAY RESULTS. THE EXAMINING PHYSICIAN MUST COMMENT ON ALL POSITIVE AND/OR SIGNIFICANT FINDINGS AND SIGN WHERE INDICATED.

PLEASE TYPE OR PRINT IN INK

1. APPLICANTIS NAME: _____
Last *First* *Other*

2. HEIGHT: _____ *in or cm*

3. WEIGHT: _____ *lb or kg*

4. CORRECTED VISION: 20: _____ *Left* 20: _____ *Right*

5. BLOOD PRESSURE: _____ *syst./diast.*

6. PULSE RATE: _____ *Circle whether regular or irregular*

7. URINALYSIS: _____ *Sugar* _____ *Albumin* _____ *Microscopic examination*

8. ELECTROCARDIOGRAM REPORT (If indicated by history or physical examination):

9. BLOOD SEROLOGY TEST FOR SYPHILIS: Test Used: _____ ☐ Pos ☐ Neg

10. A SKIN TEST FOR TUBERCULOSIS IS REQUIRED OF ALL APPLICANTS UNLESS A BCG VACCINATION HAS BEEN GIVEN RECENTLY. If vaccinated and a PPD skin test is contraindicated, a chest X-Ray is required to rule out active tuberculosis.

Tuberculin Skin Test: PPD Test: _____ ☐ Pos ☐ Neg

BCG Vaccine Given: ☐ No ☐ Yes Date of Series: _____

Date and Result of Chest X-Ray: _____

11. CLINICAL EVALUATION: (Please provide an answer to each item. Abnormal findings must be fully explained in the space provided.)

	NORMAL	ABNORMAL	DESCRIBE ABNORMAL FINDINGS
(a) Head, Nose, Mouth.			
(b) Ears, Hearing Acuity.			
(c) Eyes, Visual Acuity.			
(d) Lungs and Chest/Breast.			
(e) Heart, Rhythm and Sounds.			
(f) Vascular System.			
(g) Abdomen, Hernia, etc.			
(h) Rectum/Prostate, Hemorrhoids, Fistula.			
(i) Urinary System.			
(j) Spine and Extremities.			
(k) Skin, Lymph Nodes, Scars.			
(l) Neurological System/Reflexes.			
(m) Emotional Stability.			

12. THE PHYSICIAN MUST COMMENT ON ALL ITEMS MARKED iYESi IN THE *MEDICAL HISTORY* (PART I) AND COMMENT ON ANY CONDITION DISCOVERED DURING THE EXAMINATION.

13. PHYSICIANIS SUMMARY STATEMENT AND DIAGNOSIS:

MEDICAL HISTORY AND EXAMINATION FORM

14. IMMUNIZATION REQUIREMENTS

The applicant is responsible for obtaining the required immunizations for entry into the United States. The *WHO International Certificate of Vaccination* is the proper document for recording immunizations or vaccinations. Universities require proof of immunization against the following diseases:

MEASLES (Rubeola)

Date of Live Immunization: _____

or Date of Disease: _____

RUBELLA

Date of Immunization: _____

or Date of Rubella Titer: _____

NOTE: HISTORY OF DISEASE IS NOT ACCEPTABLE PROOF OF IMMUNITY TO RUBELLA.

RESULTS: _____

POLIO

Date series completed, type: _____

MUMPS

Date of Immunization: _____

DIPHTHERIA (DPT), Whooping Cough, Tetanus

Date series completed: _____

TETANUS BOOSTER (Most Recent): _____

I have completed my physical examination to the best of my knowledge and have reviewed the applicantís medical history, laboratory evaluations, tuberculin skin tests, and immunization record. I certify that the applicant is free of active tuberculosis, and any other contagious diseases.

It is my opinion that the applicantís physical and emotional condition is satisfactory for a full course of study, research, or lecturing in an academic environment and that there are no limitations on activity or special assistance expected for the duration of the grant period proposed.

☐ **YES** ☐ **NO**

SIGNATURE: _____ NAME OF PHYSICIAN (printed): _____

DATE: _____ COUNTRY WHERE LICENSED: _____ NUMBER: _____

ADDRESS OF PHYSICIAN: _____

FOR REVIEWING AUTHORITY USE ONLY:

The applicantís history, physical examination results, and examining physicianís opinion have been reviewed and are found to be **complete/incomplete** and **meet the standards/do not meet the standards** for the proposed academic grant.

REVIEWED BY: _____ DATE: _____

SIGNATURE: _____

ORGANIZATION: _____