



# CALIFORNIA YOUTH SOCCER ASSOCIATION

## NATIONAL "D" COURSE

**Location:** Redding Soccer Park – 9800 Old Oregon Trail, Redding, CA 96003  
**Course Date:** Jan 29, 30 & 31 - Feb 5, 6 & 7  
**Course Contact:** Keith Stewart  
**Address:** P.O. Box 990010 Redding, CA 96099  
**Phone #:** 530-244-8464 **Email:** kstewart@sebinc.net  
**Course Fee:** \$350.00

**Prerequisites:** CYSA E/D LICENSE (CYSA recommends taking the National D 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 National D license certificate until you submit proof of attending a referee course.

Mail required documents and deposit to: Course Contact

**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 \$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 National "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**

<b>CANDIDATE INFORMATION</b>			
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)			
<b>EMERGENCY CONTACT INFORMATION</b>			
<b>Please complete the following with contact information of a person that can be reached while you are attending the course.</b>			
Name:	Relationship to you:		
Work Number:	Home Number:		
Cell Number:	Alternate number:		
<b>Alternate Contact:</b>	Work Number:		
Home Number:	Cell Number:		