APTOS SOCCER CLUB ADVANCED SOCCER TRY-OUTS

Last Name_____ First Name_____

Street Address _____ City_____ Zip _____

Primary Phone _____ Alternate Phone _____ Email _____

Parents/Guardian's Names _____ and _____

School _____ Age _____ Date of Birth _____/_____/_____

Number of years playing soccer? _____ _____ _____
Select Competitive Recreation

Positions you played last Fall _____

Preferred Positions 1._____ 2._____

Are you willing to play Goalkeeper? _____ Can you play games/tournaments on Sundays? _____

Do you have any vacations or scheduled activities planned for July – November? If so, please list the dates (i.e. piano practice, gymnastics, Junior guards, etc.)

_____

List any medical problems and/or prohibitions _____

RELEASE OF LIABILITY & ASSUMPTION OF RISK AGREEMENT

I/we do hereby give our permission for my/our child to participate in tryouts for the Advanced Soccer team. I/we realize that such participation involves the potential for injury which is inherent in all sports. I/we acknowledge that soccer is a dangerous sport and could lead to minor and/or major injuries. In consideration for the privilege to tryout for the Advanced Soccer team, I/we, and on behalf of my heirs, assigns, and the next of kin, release, indemnify, hold harmless and promise not to bring action, of any kind, against Aptos Soccer Club, its agents, coaches, officers, league directors, officials, sponsors and any others having an interest in the tryouts from all liability, negligence, causes of action, claims, demands and damages of every kind which may arise out of participation in any and all activities during tryouts. I/we acknowledge that I/we have read this release of liability and assumption of risk agreement, fully understand its terms, understand that I/we have given up substantial rights by signing it and sign it freely and voluntarily without any inducement.

Parent/Legal Guardian Signature _____ Date _____

CONSENT FOR MEDICAL TREATMENT

As the parent/legal guardian of the above named player, I/we hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.

Signature_____ Date _____