



LOCATION:



TODAY'S DATE:



POST-TRYOUTS ASSESSMENT - CHECK-IN SHEET

Age Group: U__ (Born in: _____)

A PARENT MUST SIGN ON THE LAST COLUMN WAIVING LIABILITY.

MEDICAL TREATMENT AUTHORIZATION AND LIABILITY WAIVER

I hereby give my consent to have an athletic trainer, coach, emergency medical technician, nurse, medical treatment facility, and/or doctor of medicine or dentistry or associated personnel 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 understand treatment for injury will be based on information provided herein. I hereby authorize emergency transportation of the applicant/participant to a medical treatment facility should an individual listed above consider it to be warranted. I recognize the possibility of physical injury or disease associated with soccer, and hereby release, discharge, and otherwise indemnify the club, their sponsors, the USSF and its affiliated organizations, and the employees, contractors and associated personnel of these organizations, against any claim by or on behalf of the registered soccer player as a result of that player's participation in the Real Soccer Club Soccer tryouts, assessments, and/or programs and/or being transported to or from the same, which transportation I hereby authorize. Medical insurance is not provided with your participation. (The words "I" and "we" in this form refer to parents/guardians).

Vest # & color	PLAYER'S NAME	D.O.B.	Phone #: (xxx) xxx - xxxx	E-mail	CITY	I agree with the above waiver. PARENT SIGNATURE: