

SPIRIT UNITED

2009-10 TRYOUT FORM

<u>Birth date</u>	<u>Boys Teams</u>	<u>Girls Teams</u>
8/1/92-7/31/93	<input type="checkbox"/> Boys U-17	<input type="checkbox"/> Girls U-17
8/1/93-7/31/94	<input type="checkbox"/> Boys U-16	<input type="checkbox"/> Girls U-16
8/1/94-7/31/95	<input type="checkbox"/> Boys U-15	<input type="checkbox"/> Girls U-15
8/1/95-7/31/96	<input type="checkbox"/> Boys U-14	<input type="checkbox"/> Girls U-14
8/1/96-7/31/97	<input type="checkbox"/> Boys U-13	<input type="checkbox"/> Girls U-13
8/1/97-7/31/98	<input type="checkbox"/> Boys U-12	<input type="checkbox"/> Girls U-12
8/1/98-7/31/99	<input type="checkbox"/> Boys U-11	<input type="checkbox"/> Girls U-11
8/1/99-7/31/00	<input type="checkbox"/> Boys U-11	<input type="checkbox"/> Girls U-10

Personal (Please Print Clearly)

Name _____

Address _____

City, State, Zip _____

Phone (_____) _____ Birth Date _____

E-Mail _____

School Grade _____ (Fall 2008) _____

Parents Names _____

Any Medical History or Comments that the Coach should be aware of:

Soccer Experience

Preferred Position (Circle One) Goalkeeper Defender Midfielder Forward

Current Club/Team _____

Other Teams ID2 Select ODP Region Team National Team

Other Honors or Notes:

ACYS USE ONLY BELOW

Player Tryout # _____

MEDICAL RELEASE FORM

I, _____ (Parent/Guardian's Name) hereby give permission for any and all medical attention to be administered to my child _____ (Child's name) in the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. I also assume the responsibility for the payment of any such treatment; this release is effective for the period of one year from the date given below.

ADDRESS: _____

HOME PHONE: _____

INSURANCE COMP: _____

POLICY NUMBER: _____

I in case I cannot be reached, and of the following persons is designated to act on my behalf.

COACH: _____

ASST. COACH: _____

MANAGER: _____

* A league representative where my child is playing.

* Any tournament representative where my child is participating in a tournament

PHYSICIAN: _____

ADDRESS: _____

PHONE: _____

KNOWN ALLERGIES: _____

SIGNATURE: _____ DATE: _____

(PARENT/GUARDIAN)