Solano Soccer Club

P.O. Box S
Fairfield , Ca. 94533

Number:__________
Age Group:________
Gender: M / F

CLUB USE ONLY

Tryout Application
PLEASE PRINT

Date ___/______/________

Player Name:____ Male____Female____
Please Print

Date of Birth__________________________ Players age as of August 1st_____years old

Mailing Address__________________________City________________Zip__________

Home Phone #_________________________Cell Phone #__________________

Email :____

All players are required to attend, actively participate, and complete a minimum of two (2) scheduled tryouts to be considered for a selection by the Solano Soccer Club. If a player is unable to actively participate they must complete at "Tryout Wavier" form to be exempt from active participation.

Player signature:______________________________ Date:________/_____/_________

Player Signature:______________________________Date:_______/______/_________

Player Signature:______________________________Date:_______/______/_________

Player Signature:______________________________ Date:______/_______/_________

CONSENT FOR MEDICAL TREATMENT (MINOR)

As the parent or legal guardian of the above named player I 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 dependant.

Parent/Guardian name: (**please print**)____________________________________

Parent/Guardian Signature___________________________Date______/______/____