



www.southbayforce.net

2012 / 2013 Tryout Application

Our mission is to be the premier soccer club in the South Bay by providing the highest quality coaching to committed athletes. We provide a structured training environment geared to develop team success as well as individual player growth. We strive to achieve maximum bracketing potential to create opportunities for our players beyond Club soccer.

Southern California Developmental Soccer League (SCDSL) Age Divisions

Age Divisions are comprised of players born before the 1st day of August of that seasonal year.

Division	Birthdate	Division	Birthdate
U8	August 1, 2004 to July 30 2005	U14	August 1, 1998 to July 30 1999
U9	August 1, 2003 to July 30 2004	U15	August 1, 1997 to July 30 1998
U10	August 1, 2002 to July 30 2003	U16	August 1, 1996 to July 30 1997
U11	August 1, 2001 to July 30 2002	U17	August 1, 1995 to July 30 1996
U12	August 1, 2000 to July 30 2001	U18	August 1, 1994 to July 30 1995
U13	August 1, 1999 to July 30 2000	U19	August 1, 1993 to July 30 1994

Tryout Number _____
(to be completed by SBF Staff)

Player Information

Player name _____ DOB _____ Age _____
 Division _____ Preferred Position (s) _____
 Address _____ City /Zipcode _____

Soccer Experience

Club _____ years AYSO _____ years
 Current Club Team and Bracket _____

Parent Information

Parent / Guardian name(s) _____
 Home Phone _____ Cell Phone _____
 Email address _____

South Bay Force Tryout Information and Release

I hereby give my permission for the above player to participate in the South Bay Force tryouts for the 2012/2102 season. I understand that as a condition of admittance as a participant, I the undersigned, release South Bay Force, its officials and members from any liability for any injury or illness, mental or physical, due to the players participation during or related to the South Bay Force tryouts. IN the event of any accident or injury, I (we) the undersigned Parent(s)/Guardian(s) give my/our consent for emergency medical care prescribed by a duly licensed Doctor of Medicine and/or Doctor of Dentistry. I hereby grant authority to a qualified physician or dentist to render such medical treatment as said physician and/or dentist deems necessary under the circumstances and to preserve the life, limb, or well being of my dependent.

Parent/Guardian Signature _____ Date _____
 Parent/Guardian Name (print) _____