**Medical Waiver/Health Certification Form**

**To Whom it May Concern:**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City/State/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

This certifies that I, the above named individual, have chosen to participate voluntarily in the CCSOA Referee Activity to which a medical examination by a qualified medical examiner IS recommended by CCSOA.

I consider myself to be physically capable of handling the rigors required for normal participation in soccer games as a referee or assistant referee, for activities simulating game conditions, including the physical performance events listed below. I understand that the battery of events will be administered in numerical order on the same date with

intervals between events not to exceed ten(10) minutes. I understand there are target performances suggested as listed below for each event.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Event 1 | Event 2 | Event 3 |
|  | AEROBIC RUN | 50 METER AR | SHUTTLE |
|  | 12 minutes | 50 meter | 7 x 30 meter |
| CCSOA Performance Objectives | n/a | n/a | n/a |

**AGAIN**, I have chosen to participate voluntarily in the CCSOA Referee Activity with full knowledge of what will be required of me. I realize that a medical examination IS strongly recommended. The decision to participate either with or without the recommend medical examination was a conscious one. In light of my voluntary choice to participate, I specifically agree to waive any and all legal rights for claims of any nature whatsoever that I may have now or in the future against CCSOA or any person or persons representing CCSOA for any injury sustained while participating in these activities.

I certify that I have read the Medical Waiver/Health Certification Form and understand its contents as evidenced by my signature below.

I (have) (have NOT) completed the recommended medical examination.

(select and circle one)

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Participant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_