



Add photo
Here

COACHING COURSE CANDIDATE APPLICATION

Name: _____ E-Mail: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell or Business Phone: _____

Date of Birth: ___/___/___ Place of Birth: _____

Gender: Male / Female U.S. Citizen: Yes / No

Course Registration:

Course: National Youth Certificate

Course Location: Lindenwood University, St Charles, Mo 63301

Course Dates: January 2nd – 4th, 9th – 11th, 2009

Existing License(s): _____
Issued by USSF, NSCAA, Other Date Received/Date Renewed License Level & #

Member of US Soccer Coaching Organization? Member # _____ Exp. Date _____

Member of US Youth Soccer Coaches Connection? Member# _____ Exp. Date _____

____ T-Shirt Size (M, L, XL, XXL)

Emergency Contact: _____ Telephone Number: _____

____ If you have a disability or need special accommodations or assistance, please check here and contact the hosting State Association.

Candidate Has Approval To Take State Youth Coaching Module Instructor Course Upon Successful Completion of NYCC.

State Director Of Coaching

State Association



**NATIONAL YOUTH LICENSE
COACH HEALTH REPORT**

(To be completed and submitted upon check-in.)

THIS FORM DOES NOT NEED TO BE COMPLETED BY PHYSICIAN

Name _____ Date of Birth _____

Home Address _____ City _____

State _____ Zip _____ Home Phone _____

Family Physician _____

Office Phone _____

PLEASE ANSWER EVERY QUESTION ABOUT YOUR HEALTH:

- | | |
|---|----------------|
| 1. Has had any injuries requiring medical attention. | Yes ___ No ___ |
| 2. Has had illness lasting more than one week. | Yes ___ No ___ |
| 3. Is under a physician's care now. | Yes ___ No ___ |
| 4. Takes medication now. | Yes ___ No ___ |
| 5. Wears glasses ___ Wears contact lenses ___ | Yes ___ No ___ |
| 6. Has had a surgical operation. | Yes ___ No ___ |
| 7. Has been in hospital (except for tonsillectomy) | Yes ___ No ___ |
| 8. Has high blood pressure, abnormal heart rate or any heart disease. | Yes ___ No ___ |
| 9. Has had trouble with dehydration (excess loss of salt water). | Yes ___ No ___ |
| 10. Has had heat stroke. | Yes ___ No ___ |
| 11. Has any known drug, food or pollen allergy. | Yes ___ No ___ |
| 12. Has been immunized against flu ___ polio ___ tetanus ___ | Yes ___ No ___ |
| 13. Should not participate in strenuous exercise. | Yes ___ No ___ |

PLEASE EXPLAIN ANY YES ANSWERS TO ANY OF THE QUESTIONS:

(YOU MUST COMPLETE BOTH SIDES OF FORM IN ORDER TO ATTEND SCHOOL)

RELEASE OF LIABILITY

NAME (PRINT) _____ MALE ___ FEMALE ___

ADDRESS _____

CITY & STATE _____

PHONE # () _____
 Area code

DATE OF BIRTH _____

Being fully cognizant of the physical training requirements of the UNITED STATES SOCCER FEDERATION COACHING SCHOOL, I represent that I am physically able to participate and hereby hold the U.S.S.F., their coaching staff and each of their administrators harmless for any injury or medical problem that might occur. I assume the risk of injury or medical problem, and I release and waive any claim that might be made by me or my heirs upon the aforesaid.

Signature _____ Date _____

Being fully cognizant of the physical training requirements of coaching courses, I represent that I am physically able to participate and hereby hold US YOUTH SOCCER, its State Associations, their coaching staff and each of their administrators harmless for any injury or medical problem that might occur. I assume the risk of injury or medical problem, and I release and waive any claim that might be made by me or my heirs upon the aforesaid.

Signature _____ Date _____