MEDICAL WAIVER / HEALTH CERTIFICATION FORM

THE SIGNED BELOW ACKNOWLEDGE AND CERTIFIES THAT I HAVE CHOSEN TO PARTICIPATE VOLUNTARILY IN THE INDIANA STATE REFEREE ASSOCIATION AND THE UNITED STATES SOCCER FEDERATIONS REFEREE ACTIVITY TO WHICH A MEDICAL EXAMINATION BY A QUALIFIED PHYSICIAN IS RECOMMENDED BEFORE PARTICIPATION BY THE INDIANA STATE REFEREE ASSOCIATION.

I UNDERSTAND THAT THE BATTERY OF PHYSICAL EVENTS WILL BE ADMINISTERED IN THE FOLLOWING ORDER ON THE SAME DAY, WITH A BREAK IN BETWEEN THE 2 EVENTS. I UNDERSTAND THERE ARE TARGET PERFORMANCE REQUIREMENTS FOR EACH EVENT.

A. **SPRINT TEST: (5) CONSECUTIVE SPRINTS OF 30 METERS EACH. EACH SPRINT TO BE COMPLETED IN NO MORE THAN 4.7 SECONDS.**
B. **INTERVAL TEST: (10 LAPS) ON A 400 METER TRACK. EACH LAP CONSISTS OF (4) PERIODS OF SPRINTING FOR 75 METERS FOLLOWED BY A PERIOD OF WALKING FOR 25 METERS AFTER EACH SPRINT. EACH SPRINT PERIOD TO BE COMPLETED IN NO MORE THAN 15 SECONDS. EACH WALK PERIOD TO BE COMPLETED IN NO MORE THAN 20 SECONDS.**

_____ **(initial here)** I HAVE CHOSEN TO PARTICIPATE IN THIS PHYSICAL TESTING VOLUNTARILY WITH FULL KNOWLEDGE OF WHAT IS REQUIRED OF ME. THE DECISION TO PARTICIPATE EITHER WITH OR WITHOUT A MEDICAL EXAMINATION WAS MY OWN DECISION. I SPECIFICALLY AGREE TO WAIVE ANY AND ALL LEGAL RIGHTS FOR CLAIMS OF ANY NATURE WHATSOEVER THAT I HAVE NOW OR IN THE FUTURE AGAINST THE UNITED STATES SOCCER FEDERATION AND ITS MEMBERS OR ANY PERSON OR PERSONS REPRESENTING THE UNITED STATES SOCCER FEDERATION AND THE INDIANA STATE REFEREE ASSOCIATION FOR ANY INJURY OR DEATH SUSTAINED WHILE PARTICIPATING IN THESE ACTIVITIES.

I _____ CERTIFY THAT I HAVE READ THIS MEDICAL WAIVER/HEALTH CERTIFICATION FORM AND UNDERSTAND ITS CONTENTS AS EVIDENCED BY MY SIGNATURE BELOW.

_____ **(initial here) The distance and times may be different; however, the intensity and the physical demand on the body are vigorous. You have the option to opt-out of the fitness test at any time.**

_____ **(initial here) If you have any COVID-19 symptoms, been diagnosed with COVID-19, or your physician advised you not to participate in any physical activities, please DO NOT come to the testing or training.**

☐ I HAVE ☐ I HAVE NOT COMPLETED THE RECOMMENDED MEDICAL EXAMINATION.

_____ _____

SIGNATURE OF PARTICIPANT DATE SIGNED