



# **DUQUESNE CHEERLEADING**

**THE NEW COACHES WELCOME EVERYONE TO TRYOUT  
FOR THIS NEW AND EXCITING PROGRAM!**

## **TRYOUTS**

**Date: 9/2/2008 & 9/4/2008**

**Time: 7-10:00 PM**

**Location: Des Places Hall Wrestling  
Room**

**(located between McClosky field and Mercy  
Hospital)**

### **Tryout Requirements:**

- Band Dance/Fight Song
- Cheer
- Tumbling (minimum standing handspring, or ability to get one)
- Stunting (straight-up extension, walk-in liberty or other elite level one-leg stunt, full-down cradle)

**For questions please  
contact the coaches**

**Kristin (412) 600-7827**

**Cyndi (412) 445-0226**

**-OR-**

**Check out the website**

**DUQUESNE UNIVERSITY  
DEPARTMENT OF ATHLETICS  
CHEERLEADING TRYOUT LIABILITY WAIVER FORM**

1. I certify that I have passed a physical examination by a duly licensed physician who has placed no restrictions on my physical activity. I agree to present a written copy of this examination to the Head Cheerleading coach at the time tryouts begin.
2. I understand that having passed a physical examination does not necessarily mean that I am physically qualified to engage in athletics, but only that the examiner did not find a medical reason to disqualify me. I do not have any medical or emotional condition which would endanger my health and well-being by engaging in strenuous activity.
3. I understand and accept the risk of injury, permanent disability and death inherent in the sport. By signing below, I pledge to do my best to reduce these risks by keeping in the best physical condition and following the advice of the attending athletic trainer and coach concerning the prevention, treatment and rehabilitation of athletic injuries.
4. I certify that I have primary medical coverage and I release Duquesne University/Duquesne University Department of Athletics of any financial obligation for any medical bills incurred as a result of injury during this tryout period.
5. I understand that I am not entitled to facilities or services of the athletic training room during this tryout period except for emergency care.
6. I give the sports medicine staff, the student health center staff and all consulting physicians my permission to exchange, written or orally, any information concerning any illness or injury with others.

I, the undersigned, have read and understand this acceptance of risk liability waiver and agree to follow any advice and procedures set forth. I also hereby release Duquesne University/Duquesne University Department of Athletics, its agents and employees from any liability caused by, or rising out of participation in the University's athletic program unless solely and directly caused by negligence of university agents or employees.

***THIS IS A RELEASE OF LEGAL RIGHTS. READ CAREFULLY BEFORE SIGNING.***

Printed Name of Tryout Athlete: _____	Signature of Tryout Athlete: _____
Date: _____	Date: _____
Printed Name of Parent/Guardian (under 18 years of age): _____	Parent's Signature: _____
Address: _____	City: _____
State: _____	Zip Code: _____
Home Phone: _____	Parent's Work Phone: _____

Insurance Information:	Name of Insurance Company: _____
	Policy Number: _____

***I certify that I am covered by the above insurance company by signing below.***

Participant's Signature: \_\_\_\_\_  
Parent's Signature (if participant is under the age of 18): \_\_\_\_\_  
Witness' Signature (must be signed by a witness): \_\_\_\_\_  
Today's Date: \_\_\_\_\_