ALBANY JUNIOR SOCCER
ASSOCIATION INC PO BOX 5132
ALBANY WA 6331
ABN: 78 875 272 929

COUNTRY WEEK TRIALS - 2026

COMPLETED FORMS TO BE HANDED INTO THE COUNTRY WEEK COORDINATOR AT THE FIRST TRIAL – NO FORMS TO BE SENT VIA EMAIL

SURNAME: _____

FIRST NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

PARENTS MOBILE: _____

PLAYERS MOBILE: _____

PARENTS EMAIL: _____

PLAYERS EMAIL: _____

TEAM & AGE GROUP YOU CURRENTLY PLAY FOR IN THE LEAGUE;

PREFERED POSITION: 1._____ 2._____

ARE YOU TRIALING AS A GOALKEEPER? YES/NO

PLEASE LIST THE DATES OF ANY HOLIDAYS YOU HAVE BOOKED BETWEEN NOW AND SEPTEMBER

_____

Please provide a recent photo of player trialing with completed form at the first trial.

AGE GROUP TRIALLING FOR:

U11's born 2015/ 2016 (Plus players born 01.01.2017 - 30.06.2017*) ☐
U12's Girls born 2014/ 2015/ 2016 ☐
U13's born 2013 / 2014 ☐
U14's Girls born 2012/ 2013 ☐
U15's born 2011/ 2012 ☐
U17's Boys born 2009 / 2010 ☐
U17's Girls born 2009/ 2010 / 2011 ☐

Should I be selected for a country week team:

I understand that I am required to source my own accommodation in Perth for the week of the competition. Trials are open to all players registered with the AJSA who meet the age requirements. Should I be selected to play for country week I am aware that there will be fees such as the Country Week Levy plus any additional items I wish to purchase. .

SIGNED: _____

* Players successful in selection from this age group will require formal assessment by Football West prior to participating

Coordinator: Jane Baines **Email: countryweek@ajsa.com.au**

2026
HEALTH FORM

Players Name: _____ **DOB:**_____ /_____ /_____

Emergency contact: _____

Mobile: _____ **Work:** _____ **Home:** _____

Does the player suffer from the following: (please circle)

Respiratory Problems	High Blood Pressure	Asthma/Bronchitis
Diabetes	Epilepsy	Allergies
Headaches/Migraines	Eye/Ear problem	Digestive Disorder
Skin Problem	Emotional Illness	Other

If you marked any of the above, please provide details: _____

_____

_____

Date of last tetanus vaccination: _____ /_____ /_____

Any pre-existing injuries: _____

_____

_____

Will the player require medication during the tournament: YES / NO

Please provide details: _____

_____

Any special dietary needs: _____

_____

Medicare Number: _____

Ambulance Cover: _____

Private Insurance Cover Number: _____

Please provide any further information you feel will be of assistance: _____

I hereby confirm that all information provided above is true and correct and give my consent for the player named above to attend the event and for Football West to seek and authorize medical or other assistance as may be required.

_____	_____	_____
Parent/Guardian Name	**Signature**	**Date**