YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

This **must be** completed - legibly - and signed in all areas by both the player and his/her parent or guardian. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential.

By signing this form, the participant affirms having read and agreed to the terms and conditions listed below.

Club: ______________________ Team Name: ______________________

☐ Male ☐ Female

First Name ____________ Last Name ____________ Birth Date ________ Age ____

Primary Contact: Parent or Guardian

Name: ______________________ Address: ______________________

City, State & Zip: ______________________

Primary Phone: ______________________ Alternate Phone: ______________________

Secondary Contact: ☐ **Parent/Guardian** ☐**Other** ______________

Name: ______________________

Primary Phone: ______________________ Alternate Phone: ______________________

Primary Insurance Co ______________ Primary Group/Policy # __________ / __________

Family Physician Name ______________ Physician Phone ______________

Please elaborate on <u>any medical conditions</u> of which we should be aware:

Please list any <u>medications</u> currently being taken:

In the past 24 months, have you been tested, diagnosed and/or treated for a concussion: ☐ Yes ☐ No

If yes, provide the date (months and year), who performed the testing/diagnosing/treatment and what was the outcome:

Please list any <u>allergies</u>:

If None, please write None.

Participant Signature (regardless of age): ______________________ Date: __________

Participant, ______________________, has my permission to participate in training, competition, events, activities and travel sponsored by USA Volleyball or any of its Regional Volleyball Associations (RVAs). I approve of the leaders who will be in charge of this program. I recognize that the leaders are serving to the best of their ability. I certify that the participant has full medical insurance with the company listed above. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult team personnel to release this information in the event of a medical emergency to a third-party medical provider. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Parent/Guardian Signature: ______________________ Date: __________

Relationship to Participant: ______________________

If, during the course of my daughter's/son's activities in volleyball, she/he should become ill or sustain an injury, I hereby **authorize** you to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred through my insurance company.

Signature: ______________________ Date: __________

Parent/Guardian

or

I **do not authorize** emergency medical/dental care for my daughter/son.

Signature: ______________________ Date: __________

Parent/Guardian

STATE OF ______________) COUNTY OF ______________)

SWORN TO BEFORE ME, a Notary Public, by said ______________ personally known to me this __________ day of ______________ ,20 ______

My Commission Expires ______________

Notary Public