Tamarack Beach Volleyball Club: Carlsbad, CA.

MEDICAL RELEASE FORM

This must be completed - legibly - and signed in all areas by both the player and his/her parent or guardian. By signing this form the participant affirms having read it.

First Name_____ Last Name _____

Birthdate:_____ Age_____ Graduation year_____

Circle One: Male Female

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 any medical conditions of which we should be aware (if none, write NONE): _____

Any medications currently being taken (if none, write NONE):

Any allergies (if none, write NONE): _____

Participant Signature _____ Date_____

(Regardless of age):

Participant has my permission to participate in training, competition, events, activities and travel sponsored by Tamarack Beach Volleyball Club. 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 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 all bills incurred through my insurance company or otherwise.

Signature: _____ Date:_____