YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

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

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

Club: _____ Team Name: _____

_____ _____ _____ _____

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 any medical conditions of which we should be aware:

Please list any medications 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 allergies: (If None, please write None.)

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 oversee 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 procession of authorized 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 names 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 activities in volleyball, she 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.

Signature_____ Date:_____
(parent/guardian)