FLORIDA AAU VOLLEYBALL PROGRAM
Registration and Medical Release Form

This form must be carried with the coach during all training and competitions. Please complete **all** sections of this form. Both the player and their parent/guardian **must** sign in all appropriate areas. By signing this form, the participant and parent/guardian affirms they have read and understand it.

LAST NAME _____ FIRST NAME_____ MI_____

STREET ADDRESS_____

CITY _____ STATE _____ ZIP CODE _____

BIRTH DATE _____ AGE _____ AAU MEMBERSHIP NO. _____

Club NAME _____Club Code:WYWYA3_____

Please indicate which session your daughter/son will be participating in.

Competitive Session ☐ June 29th - July 31st

Beginner Session ☐ July 3rd, 10th, 24th, and 31st (Fridays Only)

The Participant,_____ , has permission to participate in the AAU Volleyball Program. I certify that the participant has full medical insurance with the company listed below and is physically fit to engage in the activities of the program. I approve the leaders and coaches of this program and recognize that they will serve to the best of their ability.

MUST SIGN: _____ Date: _____
PARTICIPANT SIGNATURE

MUST SIGN: _____ Relationship: _____
PARENT/GUARDIAN SIGNATURE

Print Name:_____
PARENT/GUARDIAN

PHONE _____ OTHER PHONE _____

EMAIL _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

INSURANCE COMPANY _____

GROUP # _____ POLICY # _____

DOES THIS POLICY COVER SPORTS RELATED ACCIDENTS?
(CIRCLE ONE) YES / NO

MEDICAL RELEASE:

I recognize that all sports, including volleyball, pose a risk of physical injury to the participants. If my daughter/son should become ill or sustain an injury during their activities of the volleyball program, I hereby authorize you to obtain emergency medical/dental care for which I will pay, including emergency transportation costs.

SIGN: _____ Date: _____
PARENT/GUARDIAN SIGNATURE