Blaze Volleyball Club

PARTICIPANT MEDICAL RELEASE & INDEMNIFICATION FORM 2017-18

This **must be** completed – legibly - and signed in all areas by both the participant and her parent or guardian. It is understood that this document will be kept in the possession of authorized adult representative of Blaze Volleyball Club and that reasonable care **will** be used to keep this information confidential. ***By signing this form, the participant and participant's parent/ guardian affirms having read and agreed to the terms and conditions listed below.***

ACTIVITY (circle one) **CLINIC** **TRYOUTS**

First Name:_____ Last Name:_____ Birth Date:_____ Age:_____

Primary Contact: Parent/Guardian

Name: _____ Address: _____ City:_____ Zip:_____

Primary Phone: _____Alternative Phone: _____

Secondary Contact: Parent/Guardian or Other (specify) _____

Name: _____ Address: _____ City:_____ Zip:_____

Primary Phone: _____Alternative Phone: _____

Primary Insurance Co	Primary Physician:
Primary Group/Policy #	Physician's 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 (CIRCLE ONE): **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, or **if none, please write none**:

Participant's signature (regardless of age): _____ Date: _____

Participant, , has my permission to participate in training, competition, events, activities and travel sponsored by **BLAZE VBC** I approve of the coaches who will be in charge of this program. I recognize that the coaches 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 **Blaze** personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult **Blaze** 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 program described above.

Parent/Guardian Signature: _____Date:_____

Relationship to Participant: _____

If during the course of my daughter's participation in the above noted Blaze activities, she should become ill or sustain an injury:

I authorize BLAZE representatives to use their judgement regarding obtaining emergency medical/dental care. I indemnify and release **BLAZE** and its representatives from any liability resulting from this judgement and I will assume financial responsibility for bills incurred.

Signature (parent/guardian): _____ Date: _____

Or

I do **not** authorize **Blaze** representatives to obtain emergency medical/dental care. I **do indemnify and** release **Blaze** and its representatives from any liability resulting therefrom (including not notifying Parent/Guardian).

Signature (Parent/Guardian):_____ Date: _____