Lower Hudson Volleyball Association Medical Release Form

Name: Last _____ First _____ M/F DOB ____/____/____

Primary Contact

Name _____ Relationship _____

Contact # (____) _____-_____ Alternate (____) _____-_____

Address _____
Street Town State Zip

Secondary Contact

Name _____ Relationship _____

Contact # (____) _____-_____ Alternate (____) _____-_____

Address _____
Street Town State Zip

Medical Information

Primary Insurance Company _____ Policy # _____

Family Physician Name _____ Contact # (____) _____-_____

Are there any current medical concerns? _____ Explain if yes: _____

_____

Is the player taking any medication currently? _____ Please list: _____

_____

Does the player have any allergies? _____ Explain if yes:_____

_____

I certify that the player has full medical insurance as listed above. I understand that this document will be kept confidential and only in the possession of authorized personnel. In the event of an emergency, I authorize LHVA to release this information to a third party medical provider.

Parent Signature _____ Date_____

Please initial one:

_____I **authorize emergency medical/dental care** for my daughter in case of an emergency. I assume financial responsibility for any medical bills obtained from your insurance company.

_____I **do not authorize medical/dental care** for my daughter in case of an emergency.