



AZ REGION YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

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

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

Club: _____ Team Name: _____

☐ Male ☐ Female

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 _____

If any of the below are None, Please write None.

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 known allergies:

Participant Signature _____ **Date:** _____
(regardless of age):

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 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 understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult team 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 activities described above.

Parent/Guardian Signature: _____ **Date:** _____

Relationship to Participant: _____

I, **hereby, authorize** emergency medical/dental care if, during the course of my daughter's/son's activities in volleyball, she/he should become ill or sustain an injury. 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/son. I will assume all responsibility for care for my daughter/son.

Signature: _____ **Date:** _____
Parent/Guardian