



## 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 \_\_\_\_\_

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 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: \_\_\_\_\_

If, during the course of my daughter's/son's activities in volleyball, she/he 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/son.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian

STATE OF \_\_\_\_\_ ) COUNTY OF \_\_\_\_\_ )  
SWORN TO BEFORE ME, a Notary Public, by said \_\_\_\_\_ personally known  
to me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Notary Public \_\_\_\_\_ My Commission Expires \_\_\_\_\_