



# Gulf Coast Region 2021/2022



## JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE & CONSENT 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 signed document will be kept in the possession of authorized CLUB/TEAM adult personnel at all Club, Gulf Coast Region, USA Volleyball activities and events. **By signing this form the participant as well as the participant's parent 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

and

**As the parent, I understand and authorize emergency medical/dental care for my daughter/son pursuant to Florida Law F.S. 1014.06(1). With the understanding that I specifically authorize healthcare services to be provided for my child by a healthcare practitioner, as defined by Florida Law 456.001 or someone under the direct supervision of a health care practitioner should the need arise while my child is participating in their Club, Gulf Coast Region and USA Volleyball Sanctioned activities and events.**

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