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:_____

Player Name: _____ Birth Date: _____ Age: ___ Gender: _____

Primary Contact:

Name: _____ Relationship: _____
Address: _____ Email Address: _____
_____ Phone: _____
Alternate Phone: _____

Secondary Contact:

Name: _____ Relationship: _____
Address: _____ Email Address: _____
_____ Phone: _____
Alternate Phone: _____

Insurance Information and Medical Contact:

Primary Insurance Company: _____ Physician Name: _____
Primary Group #: _____ Physician Phone: _____
Primary Policy #: _____ Emergency Contact #: _____

Please elaborate on <u>any medical conditions</u> of which we should be aware:

_____
_____
_____

Please list any <u>medications</u> 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:

_____
_____
_____

Allergies:

_____
_____
_____

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 Signature: _____ Date: _____

Relationship to Participant: _____

If, during the course of my child's activities in volleyball, she/he should become ill or sustain injury:

○ I hereby authorize you to obtain emergency medical/dental care. I will assume all financial responsibility for the bills incurred through my insurance company.
○ I hereby do not authorize medical/dental care for my child.

Parent Signature: _____ Date: _____

Relationship to Participant: _____