FLORIDA AAU VOLLEYBALL PROGRAM

MEDICAL HISTORY AND RELEASE FORM

This form must be carried with the coach during all training and competitions. Please complete **all** sections of this form. Both the player and his or her parent/guardian **must** sign in all appropriate areas. By signing this form, the participant and parent/guardian affirms they have read and understand it.

LAST NAME _____ FIRST NAME _____ MI _____ (CIRCLE ONE) M F

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

BIRTH DATE ___/___/___ AGE _____ SOCIAL SECURITY NO. _____ AAU MEMBERSHIPS NO. _____

TEAM NAME _____ DIVISION _____ HEIGHT _____ WEIGHT _____

The Participant, _____, has permission to participate in the AAU Junior National Volleyball Program. I certify that the participant has full medical insurance with the company listed below and is physically fit to engage in the activities of the program. I approve the leaders and coaches of this program and recognize that they will serve to the best of their ability.

MUST SIGN: _____ Date: _____
PARTICIPANT SIGNATURE

MUST SIGN: _____ Relationship: _____
PARENT/GUARDIAN SIGNATURE

Print Name: _____ HOME PHONE _____ WORK PHONE _____
PARENT/GUARDIAN

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP POLICY # _____ DOES THIS POLICY COVER SPORTS RELATED ACCIDENTS? (CIRCLE ONE) YES NO

MEDICAL RELEASE:

If my son or daughter should become ill or sustain an injury during his or her activities of the volleyball program, I hereby authorize you to obtain emergency medical/dental care.

SIGN: _____ Date: _____
PARENT/GUARDIAN SIGNATURE

I do not authorize emergency medical/dental care for my son or daughter.

SIGN: _____ Date: _____
PARENT/GUARDIAN SIGNATURE

MEDICAL HISTORY

	YES OR NO		DATE	PLEASE SPECIFY
ALLERGIES	Y	N		
ASTHMA	Y	N		
DIABETES	Y	N		
EPILEPSY	Y	N		
HEADACHES	Y	N		
HEART	Y	N		
KIDNEY DISEASE	Y	N		
MOTION SICKNESS	Y	N		
INJURIES:				
ANKLE	Y	N		
KNEE	Y	N		
BACK	Y	N		
HEAD/NECK	Y	N		
SHOULDER	Y	N		
ELBOW	Y	N		
WRIST	Y	N		
HAND	Y	N		
FINGER	Y	N		
OTHER	Y	N		

IMMUNIZATIONS (please state month and year):

Tetanus_____ Polio_____ Measles (Rubella)_____

Is the participant taking any medications? _____NO _____YES

If yes, please name the drug(s), dosage and frequency needed:

_____

Is there any psycho-social or physical condition for which the participant is currently under professional care?

_____NO _____YES

Please list any injuries the participant has suffered in the last two months:_____

_____

Elaborate on any other medical conditions:_____

_____

STATE OF_____

COUNTY OF_____

SWORN TO BEFORE ME, A NOTARY REPUBLIC, BY SAID_____PERSONALLY KNOW TO ME THIS_____DAY OF_____,20____.

_____**NOTARY REPUBLIC**

MY COMMISSION EXPIRES_____