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 <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:

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

If None, please write None.

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

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