



2011-2012 USAV 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. By signing this form the participant affirms having read it.

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:
Any medications currently being taken:
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 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 \_\_\_\_\_
My Commission Expires \_\_\_\_\_

Notary Public