

## **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. 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:

					🗆 Male	Female
First Name	Last Name		Birth Date	Age		
Primary Contact: Parent or Guardia Name:	n	_Address:				
Primary Phone:		City, State & Zip _Alternate Phone:				
Secondary Contact:  Parent/Guardian  Other Name:						
Primary Phone:		Alternate Phone:				
Primary Insurance Co		Primary Group/Po	olicy #		/	
Family Physician Name		Physician Phone				
Please elaborate on any medical conditions 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: 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: Date: Date: Date: Date:						
If, during the course of my daughter's/son's activities in volleyball, she/he should become ill or sustain an injury, I hereby <b>authorize</b> 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 <b>do not authorize</b> emergency medic Signature: Parent/Guardian	cal/dental care for my daugh	iter/sonDate	2:			