## THIS FORM IS TO BE CARRIED TO ALL SANCTIONED COMPETITIONS & PRACTICES.



## **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:	and agreed to the terms and conditions list	eam Name:			
			<b>-</b> -	☐ Male	☐ Female
First Name	Last Name	Birth Date	Age		
Primary Contact: Parent or Guardi	an				
Name:	Addres				
		ate & Zip			
Primary Phone:	Alterna	te Phone:			
Secondary Contact:   Parent/ Name:	Guardian □Other				
Primary Phone:	Alterna	te Phone:			
Primary Insurance Co	Prima	ry Group/Policy #		/	
Family Physician Name	Physic Physic	ian Phone			
Please elaborate on any medical co	onditions of which we should be awar	e:			
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:  \( \square\$ Yes  \square\$ 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		Date:			
(regardless of age):		h		:-:	tata -
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:					
emergency medical/dental care. I will Signature:  Parent/Guardian	son's activities in volleyball, she/he should assume financial responsibility for the bill		•	•	you to obtain
or					
<u> </u>	ical/dental care for my daughter/son.				
Signature: Parent/Guardian		Date:			