# 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: _____

First Name: _____ Last Name: _____ Birth Date: _____ Age: ____ ☐ Male ☐ Female

**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: _____

Please list any medications 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 allergies (write NONE if no allergies): _____

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 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.
Parent/Guardian Signature: _____ Date: _____

**OR**

I **do not authorize** emergency medical/dental care for my daughter/son.
Parent/Guardian Signature: _____ Date: _____