**2023-2024 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 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: |
| 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 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 |  |  |
| 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 |  |  |  |  |