

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	n						
Name:		Address:					
Daine and Dhaman		City, State & Zip:					
Primary Phone:		Alternate Phone:					
Secondary Contact: Parent/C	Guardian □Other _	Alternate Discourse					
Primary Phone:		Alternate Phone:	-				
Primary Insurance Co		Primary Group/P	Policy #		/		
Family Physician Name		Physician Phone					
Please elaborate on any medical cor	nditions of which we shou	ıld be aware:					
Please list any <u>medications</u> currently	being taken:						
In the past 24 months, have you been If yes, provide the date (months and	_				as the outco	me:	
Please list any <u>allergies</u> :							
If None, please write None.							
Participant Signature		Date:					
(regardless of age):							
Participant, competition, events, activities and trave leaders who will be in charge of this pro full medical insurance with the company adult team personnel and that reasonal personnel to release this information in knowledge that the participant named h Parent/Guardian Signature: Relationship to Participant:	gram. I recognize that the low listed above. I understand olle care will be used to keep the event of a medical eme	all or any of its Regional eaders are serving to the and agree that this docu this information confide rgency to a third party m	best of their abument will be ke ential. I agree to dedical provider	ciations (RY pility. I cer ept in the p allow the	VAs). I approviously the poossession of a authorized ac	ve of the participant has authorized Jult team	
If, during the course of my daughter's/see emergency medical/dental care. I will a						you to obtain	
Signature:		Dat	:e:				
Parent/Guardian or							
I do not authorize emergency medic	cal/dental care for my day	ughter/son					
Signature:	Layuentai care for miy da	ugnter/son. Dat	٠6٠				
Parent/Guardian		Dat					
STATE OF) COUNTY OF				1		
STATE OF SWORN TO BEFORE ME, a Notary Public		-		ner) sonally knowi	n	
to me this	day of			,20	-	•	
		M	y Commission E				
Notary Public							

2017-2018 Season Revised 7/18/2017