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:	Team Name	<u>:</u>			
				☐ Male	☐ Female
First Name Last Nam	e	Birth Date	Age		
Primary Contact: Parent or Guardian Name:	Address: City, State & Zip				
Primary Phone:	Alternate Phone:				
Secondary Contact: ☐ Parent/Guardian ☐ Name:	Other				
Primary Phone:	Alternate Phone:				
Primary Insurance Co	Primary Group/P	olicy#		/	
Family Physician Name	Physician Phone				
Please elaborate on <u>any medical conditions</u> of which	we should be aware:				
Please list any <u>medications</u> currently being taken:					
In the past 24 months, have you been tested, diagnously likely provide the date (months and year), who performs a list any allergies:				s the outcor	me:
If None, please write None.					
Participant Signature (regardless of age):	Date:				
Participant, competition, events, activities and travel sponsored by US. leaders who will be in charge of this program. I recognize full medical insurance with the company listed above. I ur adult team personnel and that reasonable care will be use personnel to release this information in the event of a med knowledge that the participant named hereon is physically Parent/Guardian Signature:	A Volleyball or any of its Regional \ that the leaders are serving to the iderstand and agree that this docu d to keep this information confide dical emergency to a third party m	best of their al ment will be ke ntial. I agree to edical provider	ciations (RV pility. I cert ept in the p allow the a	'As). I approvicify that the possession of a	ve of the articipant has authorized lult team
Relationship to Participant:					
If, during the course of my daughter's/son's activities in vo emergency medical/dental care. I will assume financial resignature: Parent/Guardian or		rough my insu			you to obtain
I do not authorize emergency medical/dental care for	or my daughter/son				
Signature: Parent/Guardian	Dat	e:			
r ai ciit/ Quai ulali					