



MEDICAL RELEASE / WAIVER FORM

To be completed by parent or guardian. Please print in ink only. All sections of this form must be filled in. This form may be copied for additional applications. Your payment, in full, must accompany this registration package.

Participant - Last name First Name Middle Initial
Birth date (mm/dd/yy): Age: Home Phone
Home Address City State Zip Code

PRIMARY CONTACT INFORMATION (PARENT OR GUARDIAN)

Primary Contact - Last Name. First Name Phone Number Email
Relationship to participant Mother. Father other:

SECONDARY CONTACT INFORMATION (PARENT OR GUARDIAN)

Secondary Last Name First Name Phone Number Email

HEALTH INSURANCE INFORMATION

Primary Insurance Co.: Primary Policy #:
Family Physician Name: Physician Phone #:

- Please elaborate in any medical conditions of which we should be aware:
Please list any medications currently being taken:
Please list any allergies:
In the past 24-month, have you been tested, diagnosed and/or treated for a concussion? YES NO
Participant signature (regardless of age): Date: / 20

Participant has my permission to participate in the camps, training, competition, events, activities and/or travel sponsored by SVC Sarasota Volleyball Club, or any of its regional Volleyball Associations. I approve of the leaders who will be in charge of this program/ camp or tournament. I recognize that the leaders are serving to the best of their ability. I certified that the participant has full medical insurance with the company listed above. I understand and agree that this document will keep in the possession of authorized team (SVC) 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 name hereon is physically fit to engage in volleyball related activities. I further understand Sarasota Volleyball Club retains the right for publicity and advertising purposes; photographs, videos and written remarks of campers/ players while training at SVC Programs. If during the course of my daughter's activities in volleyball, should she become ill or sustain an injury, I hereby:
Authorize or Do not authorize (Select ONLY one option) you to obtain emergency medical/ dental care. I will assume financial responsibility for the bills incurred through my insurance company.

Parent/ Guardian Signature: Date: / 20