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 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 (attach a separate sheet if necessary):
_____
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 AAU 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: _____