## TEMPLATE

## 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:					
		Birth Date:			
Primary Contact: Parent or Name:					
Address:		City, State & Zip:			
Primary Phone:		Alternate Phone:			
Secondary Contact:		Other	-		
Primary Phone:		Alternate Phone:	, ,		
Primary Insurance Co:			#	/	
Family Physician Name:		Physician Phone:			
Please elaborate on <u>any me</u> conditions of which we show					
Please list any <u>medications</u> currently being taken:					
In the past 24 months, have	you been tested, diagno	osed and/or treated for a concussion:	′es □No		
If yes, provide the date (mo the testing/diagnosing/trea		formed e outcome:			
Please list any allergies (write NONE if no allergies):	:				
Participant Signature: (regardless of age):		Date:			
leaders who will be in charge o full medical insurance with the adult team personnel and that personnel to release this inforr knowledge that the participant Parent/Guardian Signature:	of this program. I recognize company listed above. I use reasonable care will be use mation in the event of a me t named hereon is physicall	, has my permission SA Volleyball or any of its Regional Volleyball As that the leaders are serving to the best of their inderstand and agree that this document will be ed to keep this information confidential. I agree edical emergency to a third party medical provid by fit to engage in the activities described above Date	sociations (RVA r ability. I certif e kept in the pose to allow the au der. I also certify	s). I approve on y that the part ssession of aut othorized adult	cicipant has horized t team
Relationship to Participant:					
	e. I will assume financial re	olleyball, she/he should become ill or sustain ar esponsibility for the bills incurred through my in Date:	surance compa	ny.	u to obtain
OR					
I <b>do not authorize</b> emergen Parent/Guardian Signature:					