**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.***

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| Club: |  | | | | | | | | | | | | | | Team Name: | | | | | |  | | | | | | | | | | | | |
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| First Name | | | | | | | | | | Last Name | | | | | | | | | Birth Date | | | | | | | Age | | | |  | | | |
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| **Primary Contact: Parent or Guardian** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | |  | | | | | | | | | | Address: | | | | | | |  | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | City, State & Zip | | | | | | |  | | | | | | | | | | | | |
| Primary Phone: | | | |  | | | | | | | | | | Alternate Phone: | | | | | | |  | | | | | | | | | | | | |
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| **Secondary Contact:** | | | | | **□ Parent/Guardian** | | | | | | **□Other** | |  | | | | | | | | | | | |  | | | | | | | | |
| Name: | | | |  | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |
| Primary Phone: | | | |  | | | | | | | | | | Alternate Phone: | | | | | | |  | | | | | | | | | | | | |
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| Primary Insurance Co | | | | | | |  | | | | | | | | Insurance Co Phone | | | | | | | | |  | | | | | | | |  |  |
| Family Physician Name | | | | | | |  | | | | | | | | Physician Phone | | | | | | | | |  | | | | | | | | | |
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| Please elaborate on any medical conditions of which we should be aware: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Please list any medications currently being taken: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| If None, please write None. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Participant Signature | | | | | |  | | | | | | | | | | | Date: | |  | | | | | | | | |  | | | | | |
| (regardless of age): | | | | | |  | | | | | |  | | | | | |  | | | | | | | | | | | |  | | | |
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| Participant, | | |  | | | | | | | | | | | | | | | | , has my permission to participate in training, | | | | | | | | | | | | | | |
| competition, events, activities and travel sponsored by USA Volleyball 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: | | | | | | | |  | | | | | | | |  | |  | | | | | | | | | | | |  | | | |
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| 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature: | |  | | | | | | | | | | | | | | | | Date: | | | |  | | | | | | | | |  | | |
|  | | Parent/Guardian | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | |
| or | | | | | |  | | | | | |  | | | | | |  | | | | | | | | | | | |  | | | |
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| I **do not authorize** emergency medical/dental care for my daughter/son. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature: | |  | | | | | | | | | | | | | | | | Date: | | | |  | | | | | | | | |  | | |
|  | | Parent/Guardian | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | |