

THIS FORM IS TO BE CARRIED TO ALL SANCTIONED COMPETITIONS & PRACTICES.



USA Volleyball

2011 USA VOLLEYBALL HIGH PERFORMANCE PROGRAM
PLAYER MEDICAL RELEASE FORM

This must be completed - legibly - and signed in all areas by both the player and his/her parent or guardian. By signing this form the participant affirms having read it.

Name Last First Birth Date Age Gender

Primary Contact: Parent or Guardian

Name Address Zip
Phone Alternate Phone

Secondary Contact: Parent/Guardian Other

Name
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:

Any medications currently being taken:

Any allergies:

If None, please write None.

Signed Date:
Participant

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 also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Signed Relationship: Date:

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.

Signed Date:
Parent or Guardian

or

I do not authorize emergency medical/dental care for my daughter/son.

Signed Date:
Parent or Guardian

STATE OF ) COUNTY OF )
SWORN TO BEFORE ME, a Notary Public, by said personally known
to me this day of , 20
My Commission Expires
Notary Public

