USAV / Wave Volleyball Club

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*** ☐ ***Other*** ______________________________
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: ____

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 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: ________________________________

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: ___________________