

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



2009 USA YOUTH & JUNIOR OLYMPIC VOLLEYBALL  
PLAYER MEDICAL RELEASE FORM

USA Volleyball

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

**Parent or Guardian of Athletes under 18 years 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 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

**FOR FLORIDA TRYOUTS ONLY**

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