



# AZ REGION 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: \_\_\_\_\_

Male  Female

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

**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 \_\_\_\_\_

**If any of the below are None, Please write None.**  
**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 known 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:** \_\_\_\_\_

**I, hereby, authorize** emergency medical/dental care if, during the course of my daughter's/son's activities in volleyball, she/he should become ill or sustain an injury. I will assume financial responsibility for the bills incurred through my insurance company.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent/Guardian

OR

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

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Parent/Guardian