YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

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This **must be** completed - legibly - and signed in all areas by both the player and his/her parent or guardian. I understand 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: Kansas United _____ **Team/Age Group** _____

First Name: _____**Last Name:** _____ **Age** _____

Primary Contact: Parent or Guardian

Name: _____ **Address** _____

City, State & Zip: _____**Primary Phone:** _____

Secondary Contact: ☐ **Parent/Guardian** ☐ **Other** _____**x**

Name: _____

Primary Phone: _____ **Alternate Phone:** _____

Primary Insurance Co: _____

Primary Group/Policy # _____

Family Physician Name: _____**Physician Phone:** _____

Please elaborate on <u>any medical conditions</u> of which we should be aware:

Please list any <u>medications</u> currently being taken:

In the past 24 months, have you been tested, diagnosed and/or treated for a concussion: ☐Yes ☐No If yes, provide date (months and year), who performed the testing/diagnosing/treatment and what was the outcome:

Please list any <u>Allergies:</u>

- **Participant Signature:**_____

Date: _____

Participant Name,_____, 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 heron is physically fit to engage in the activities described above.

Parent/Guardian Signature: _____ **Date:** _____

Relationship to Participant: _____

Or - I **do not authorize** emergency medical/dental car for my daughter/son.

Parent/Guardian Signature: _____ Date: _____