

2019-2020 USAV HP MEDICAL RELEASE

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.

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

Please elaborate on any medical conditions of which we should be aware:
Please list any medications currently being taken:
In the past 24 month, 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:
If None, please write None.

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.
Signature: Date:
Parent/Guardian

or

I do not authorize emergency medical/dental care for my daughter/son.
Signature: Date:
Parent/Guardian

For Tryouts or Programs occurring in Florida 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