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 Guard Name: Primary Phone:	lian	Address: City, State & Zip Alternate Phone:				
Name:	t/Guardian □Other	Albania da Di				
Primary Phone:		Alternate Phone:				
Primary Insurance Co Family Physician Name		Primary Group/P Physician Phone	olicy #		/	
- Indinity Filly Siciali Name		PHYSICIAH PHONE				
Please elaborate on any medical o	conditions of which we shou	ld be aware:				
Please list any <u>medications</u> currer	itly being taken:					
In the past 24 months, have you be a lifyes, provide the date (months a list any allergies: If None, please write None.	_				s the outcor	me:
Participant Signature		Date:				
(regardless of age):						
Participant, competition, events, activities and tra leaders who will be in charge of this p full medical insurance with the compa adult team personnel and that reasor personnel to release this information knowledge that the participant name	orogram. I recognize that the le any listed above. I understand a nable care will be used to keep to in the event of a medical emer	all or any of its Regional vaders are serving to the and agree that this docuthis information confide gency to a third party m	best of their al iment will be ke intial. I agree to ledical provider	ciations (RV pility. I cert ept in the p allow the a	/As). I approvitify that the possession of a	ve of the participant has authorized dult team
Parent/Guardian Signature:			Date:			
Relationship to Participant:						
If, during the course of my daughter's emergency medical/dental care. I will Signature:			nrough my insu			you to obtain
Parent/Guardian or						
I do not authorize emergency me Signature:	dical/dental care for my dau	ighter/sonDat	e:			

2024/2025 Season Revised 7/30/2024