

WAIVER, RELEASE AND INSURANCE INFORMATION

As custodial parent or court-appointed guardian of _____ (hereafter, "Child"), I do for both of Child's parents, for child and child's heirs and successors, release the Charlotte Volleyball Academy, LLC and any of its agents, employees or representatives and Carolina Union Volleyball Club and any of its agents, employees or representatives (all of the foregoing collectively "CVA") from all claims arising out of or connected with Child's participation in any CVA or CUVC program, camp, clinic, private lesson, conditioning, weight training, or any form of physical or volleyball training. I provide this release because I am mindful that athletics, physical training and competition can be a dangerous undertaking regardless of how careful or prudent any person, firm or facility might be. Further, I give permission to CVA to treat Child or arrange for medical care or treatment for Child in any situation deemed reasonably necessary by CVA. In the event that the information below changes, it is my responsibility to notify CVA of said changes. If circumstances permit, CVA shall attempt to communicate first via telephone with the following emergency contacts for Child:

Primary Emergency Contact

Secondary Emergency Contact

Name and Relationship

Phone Number

Name and Relationship

Phone Number

In the event neither emergency contact can be reached or if the urgency of the situation requires immediate attention without prior telephone contact, CVA may arrange for medical treatment for the Child at the expense of the parent or guardian signing this form. Health Insurance, PPO information for Child is as follows:

Insurance Company: _____ Policy #: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Telephone: _____

In order to seek appropriate medical care or treatment of Child, please disclose the following:

Allergies: _____

Heart Conditions or other: _____

Please specify any other important medical information that might affect medical treatment or participation in programs: _____

Printed Name of Responsible Party

Signature of responsible party

Date

**This medical release shall remain in effect from the date of its original signature through September 1, 2014.*