SRVA PIN: _____

SRVA 2014-2015
MEDICAL RELEASE FORM INSTRUCTIONS

Dear _____

Please follow the instructions below regarding the Medical Release Form

JUNIOR PLAYERS and PARENTS

1. **MEDICAL RELEASE FORM**
   A Medical Release form authorizes a club to approve medical treatment when a parent/guardian is not present.
   This form is not required for SRVA tryouts.
   Print and complete a Medical Release form.

   DO NOT SEND THIS FORM TO SRVA
   Give this completed form to the club with which you choose to play.

THIS FORM IS TO BE CARRIED TO ALL SANCTIONED COMPETITIONS & PRACTICES.

2014-2015 USAV YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

SRVA PIN: _____
11/22/14 11:39:31

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 _____

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 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 <u>allergies</u>:

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

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

Revised 08/01/2013