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PLAYER MEDICAL RELEASE FORM



This **must be** completed - legibly - and signed in all areas by both the player and his/her parent or guardian. **By signing this form the participant affirms having read it.**

Name _____

Last	First	Birth Date	Age	Gender
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Primary Contact: Parent or Guardian

Name _____ Address _____ Zip _____
 Phone _____ Alternate Phone _____

Secondary Contact: Parent/Guardian Other

Name _____
 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:

Any medications currently being taken:

Any allergies:

If None, please write None.

Signed _____ Date: _____
 Participant

Participant, _____, has my permission to participate in training, competition, events, activities and travel sponsored by _____ 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 also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Signed _____ Relationship: _____ Date: _____

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.

Signed: _____ Date: _____
 Parent or Guardian

or

I **do not authorize** emergency medical/dental care for my daughter/son.

Signed: _____ Date: _____
 Parent or Guardian