

# AAU Volleyball 4 Youth Medical Wavier Release Form

## PLAYER MEDICAL RELEASE FORM (Revised 5-1-2009)

This **must be** completed - legibly - and signed in all areas by both the player and his or her parent or guardian.

*By signing this form the participant affirms having read it. A copy of this form must be showed and on premise at any Volleyball 4 Youth Event.*

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

AAU Membership Number: \_\_\_\_\_ USAV Membership Number: \_\_\_\_\_

Player Home Number: \_\_\_\_\_ Player Cell Number: \_\_\_\_\_

Player Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

### Parent or Guardian: In Emergency, Contact:

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Cell # \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone \_\_\_\_\_

Players Primary Insurance Co. \_\_\_\_\_

Primary Group # \_\_\_\_\_ /Policy # \_\_\_\_\_

Family Physician Name \_\_\_\_\_ Physician Phone \_\_\_\_\_

**Immunizations** (please state month and year) Tetanus \_\_\_\_\_

Participant Signature \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_(Player Listed Above) has my permission to participate in training, competition, events, activities and travel sponsored by VB4Y, AAU and 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 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: \_\_\_\_\_

### To the Staff of Volleyball Leaders:

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. Is there any psycho-social or physical condition for which the participant is currently under professional care? NO YES

Is the participant currently taking any medications? NO YES

If so, please name the drug(s), dosage and frequency: \_\_\_\_\_

List any known allergies: \_\_\_\_\_

Please elaborate on any medical conditions of which we should be aware on back of this sheet:

Please list any injuries the participant has suffered in the last six months:

State special instructions to follow in case of emergency on the back of this sheet.

**I will assume financial responsibility for the bills incurred through my insurance company.**

Parent /Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

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

Parent /Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_