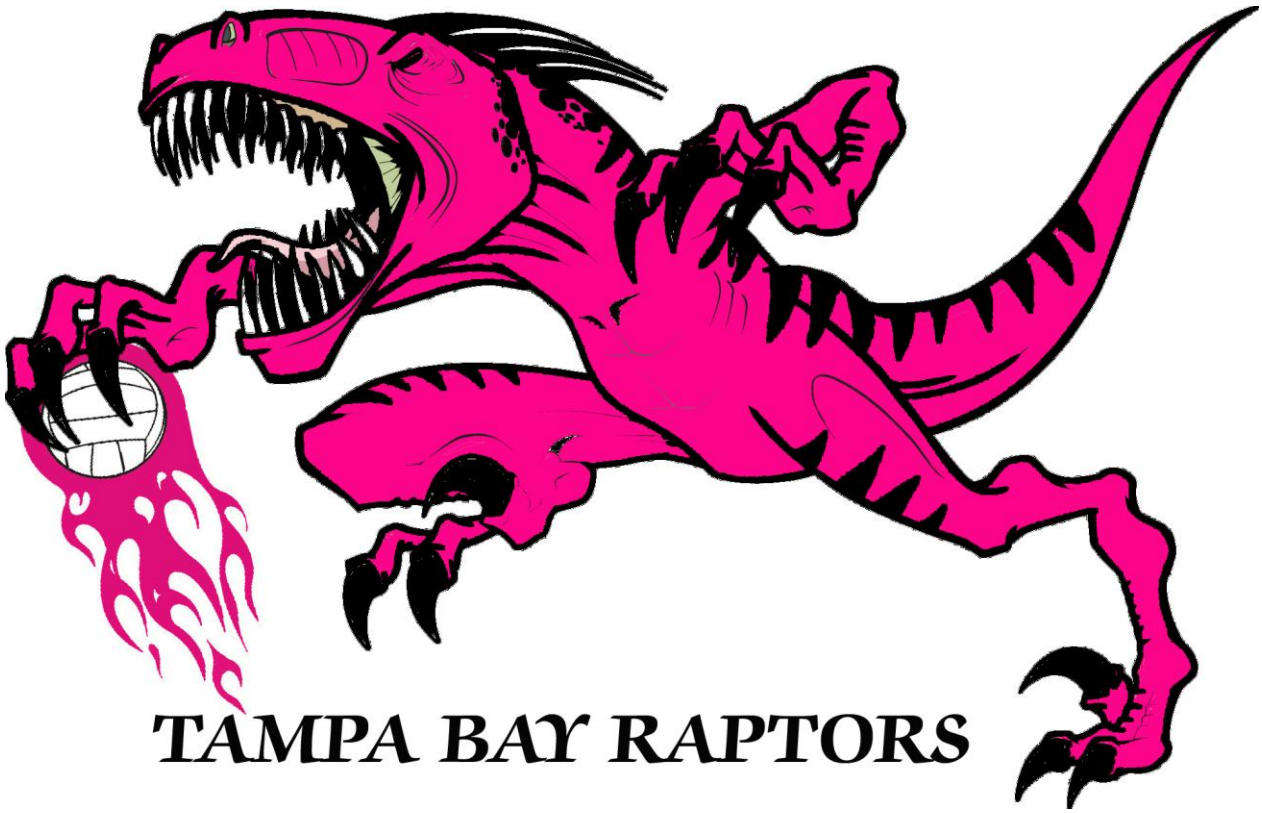
TAMPA BAY RAPTORS

2013 REGRISTRATION PACKET



WWW.TAMPABAYRAPTORS.ORG

Tampa Bay Raptors Volleyball Tryout Form

USAV AGE _____

Tryout # _____

Please make checks payable to ***Tampa Bay Raptors*** in the amount of $50

Tryout Fee _____

Player Information

Name: _____ Age: _____ Birthdate _____/_____/_____

Parent's/ Guardian's Name: _____ Emergency # _____

Address: _____ Town: _____ Zip: _____

Player's Cell: _____ Player's Email: _____

Parent's Cell: _____ Parent's Email: _____

Player Profile (Fill in and/or circle

School: _____ Grade: _____ Graduation Year: _____

Position: Outside / Middle / Setter / Right Side / Libero / Defensive Specialist / Unsure

Age: _____ Height: _____ Dominant Hand: Right / Left

Have you played Club Volleyball before? YES / NO If YES, Name of Club: _____

Are you currently playing? YES / NO If yes, what level: Varsity / JV / Middle School

RETURNING PLAYERS

Jersey Number: _____

Uniform Size: Jacket ____Pants ____ T-Shirt ____

NEW PLAYERS

Uniform Size: jersey ____ shorts ____ jacket____ pants ____ T-shirt ____

Jersey # 1st choice ____ 2nd choice ____ 3rd choice ____

By signing below, I give my child permission to participate in Tampa Bay Raptors Volleyball. I am also the legal parent or guardian of my child. I understand that the sport of volleyball and assume all risks of personal injury or death in connection therewith. I, the undersigned, hereby release and forever discharge Tampa Bay Raptors from any and all claims for damages, including personal loss, damages, or injury to my child.

I attest that my child is sufficiently physically and mentally fit to participate safely therein, and I have not been advised otherwise by a qualified medical doctor. I hereby authorize first aid and/or medical treatment necessary for my child in case of emergency. I understand that I am responsible for any charges incurred for medical treatment of my child. USA Volleyball provides ONLY secondary insurance.

All players tryout out MUST complete and signed this Tryout / Waiver Form and submit with payment.

Parent's Name: _____ **Parent's Signature:** _____ **Date:** _____

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

2013-2014 USAV 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: TAMPABAY RAPTORS 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 team/RVA 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: **X** _____ Date: _____

Relationship to Participant: _____

If, during the course of my daughter's/son's activities in volleyball, should she/he become ill or sustain an injury, I hereby

☐ **AUTHORIZE** or ☐ **DO NOT AUTHORIZE** **(Select only one option to ensure validity of this document!)**

you to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred through my insurance company.

Parent/Guardian Signature: **X** Date:

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 09/1/2012 SB

FLORIDA AAU VOLLEYBALL PROGRAM

MEDICAL HISTORY AND RELEASE FORM

This form must be carried with the coach during all training and competitions. Please complete **all** sections of this form. Both the player and his or her parent/guardian **must** sign in all appropriate areas. By signing this form, the participant and parent/guardian affirms they have read and understand it.

LAST NAME _____ FIRST NAME _____ MI _____ (CIRCLE ONE) M F

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

BIRTH DATE ___/___/___ AGE _____ SOCIAL SECURITY NO. _____ AAU MEMBERSHIPS NO. _____

TEAM NAME _____ DIVISION _____ HEIGHT _____ WEIGHT _____

The Participant, _____, has permission to participate in the AAU Junior National Volleyball Program. I certify that the participant has full medical insurance with the company listed below and is physically fit to engage in the activities of the program. I approve the leaders and coaches of this program and recognize that they will serve to the best of their ability.

MUST SIGN: _____ Date: _____
PARTICIPANT SIGNATURE

MUST SIGN: _____ Relationship: _____
PARENT/GUARDIAN SIGNATURE

Print Name: _____ _____ _____
PARENT/GUARDIAN HOME PHONE WORK PHONE

_____ _____ _____ _____
STREET ADDRESS CITY STATE ZIP

_____ _____ DOES THIS POLICY COVER SPORTS RELATED ACCIDENTS?
INSURANCE COMPANY GROUP POLICY # (CIRCLE ONE) YES NO

MEDICAL RELEASE:

If my son or daughter should become ill or sustain an injury during his or her activities of the volleyball program, I hereby authorize you to obtain emergency medical/dental care.

SIGN: _____ Date: _____
PARENT/GUARDIAN SIGNATURE

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

SIGN: _____ Date: _____
PARENT/GUARDIAN SIGNATURE

MEDICAL HISTORY

	YES OR NO		DATE	PLEASE SPECIFY
ALLERGIES	Y	N		
ASTHMA	Y	N		
DIABETES	Y	N		
EPILEPSY	Y	N		
HEADACHES	Y	N		
HEART	Y	N		
KIDNEY DISEASE	Y	N		
MOTION SICKNESS	Y	N		
INJURIES:				
ANKLE	Y	N		
KNEE	Y	N		
BACK	Y	N		
HEAD/NECK	Y	N		
SHOULDER	Y	N		
ELBOW	Y	N		
WRIST	Y	N		
HAND	Y	N		
FINGER	Y	N		
OTHER	Y	N		

IMMUNIZATIONS (please state month and year):

Tetanus_____ Polio_____ Measles (Rubella)_____

Is the participant taking any medications? _____NO _____YES

If yes, please name the drug(s), dosage and frequency needed:

_____

Is there any psycho-social or physical condition for which the participant is currently under professional care?

_____NO _____YES

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

_____

Elaborate on any other medical conditions:_____

_____

STATE OF_____

COUNTY OF_____

SWORN TO BEFORE ME, A NOTARY REPUBLIC, BY SAID_____PERSONALLY KNOW TO ME THIS_____DAY OF_____,19____.

_____**NOTARY REPUBLIC**

MY COMMISSION EXPIRES_____