SRVA 2015-2016
MEDICAL RELEASE FORM INSTRUCTIONS

Dear and :

Please follow the instructions below regarding the Medical Release Form

INDOOR 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.

2. **PLAYERS CANNOT PARTICIPATE WITHOUT THIS FORM, WHICH MUST BE SIGNED BY A PARENT OR GUARDIAN.**

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

4. **IF YOU PLAN TO PLAY IN OUTDOOR EVENTS**
   MAKE MULTIPLE COPIES OF THE COMPLETED FORM

OUTDOOR JUNIOR PLAYERS and PARENTS

1. **MEDICAL RELEASE FORM**
   A Medical Release form authorizes an event to approve medical treatment when a parent/guardian is not present.
   Print and complete a Medical Release form.

2. **PLAYERS CANNOT PARTICIPATE WITHOUT THIS FORM, WHICH MUST BE SIGNED BY A PARENT OR GUARDIAN.**

3. **DO NOT SEND THIS FORM TO SRVA!!!**
   Junior Players must present a completed SRVA or another Region Medical Release Form at each event.

4. **Players should retrieve the form after the event or request that it be shredded or otherwise destroyed.**

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

09/09/16 21:10:59

2015-2016 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: _____ Team Name: _____

_____ _____ _____ -1 ☐ 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 any medical conditions of which we should be aware:

Please list any medications currently being taken:

In the past 24 months, 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 allergies:

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