

## 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.** 

Primary Phone: Alternate Phone: Email Address:  Primary Insurance Co: Primary Group/Policy # / Family Physician	First Name:	Last Name:	Birth Date:	Age:	Grade:
Address:	Primary Contact: Par	rent or Guardian			
Primary Phone:	Name:				
Email Address:    Secondary Contact:   Parent/Guardian   Other	Address:		City, State & Zip:		
Secondary Contact:   Parent/Guardian   Other			Alternate Phone:		
Secondary Contact:   Parent/Guardian   Other	Email Address:				
Name:   Primary Phone:	Secondary Contact:	☐ Parent/Guardian ☐ Otl			
Primary Phone:					
Email Address:    Primary Insurance Co:	Primary Phone:		Alternate Phone:		
Primary Insurance Co:	Email Address:				
Family Physician Name: Physician Phone: Physician Phone: Physician Phone: Physician Phone: Physician Phone: Physician Phone: Phease elaborate on any medical conditions of which we should be aware: Please list any medications currently being taken: Please list any medications currently being taken: Physician Phone Physician	Primary Insurance Co		Primary Group/Po	licy#	
Please laborate 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 (write NONE if no allergies):  Participant Signature:    Participant,   Date:				•	
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