

TEMPLATE

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: Hot Feet Sports

Team Name: Fire Dragons 13U

Sydney Pfeiffer 04/25/2008 12 ☐ Male ☒ Female
 First Name Last Name Birth Date Age

Primary Contact: Parent or Guardian

Name: Nick Pfeiffer Address: 226 Cherry Ln.
 City, State & Zip Tiffin, IA 52340
 Primary Phone: 319-610-0176 Alternate Phone:

Secondary Contact: ☒ Parent/Guardian ☐ Other

Name: Hollie Pfeiffer
 Primary Phone: 319-573-0834 Alternate Phone:

Primary Insurance Co BCBS Primary Group/Policy # 80035 /
 Family Physician Name Boscaljohn Physician Phone 319-339-1231

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

Over a year ago, Sydney had a small fracture in her ankle. An ankle brace is required.

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.

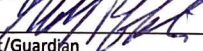
Participant Signature  Date: 11/20/2020
 (regardless of age):

Participant, Sydney Pfeiffer, 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 herein is physically fit to engage in the activities described above.

Parent/Guardian Signature:  Date: 11/20/2020

Relationship to Participant: Parent

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: 11/20/2020
 Parent/Guardian

or

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

Signature: _____ Date: _____
 Parent/Guardian