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 AS

Peyton	Anderson	04/24/2008	12	☐ Male ☑ Female
First Name	Last Name	Birth Date	Age	

Primary Contact: Parent or Guardian

Name: Summer Lang Address: 260 Washington Avenue

City, State & Zip North Liberty, IA 52317

Primary Phone: 319/331.4384 Alternate Phone:

Secondary Contact: ☑ **Parent/Guardian** ☐ **Other**

Name: Nate Anderson

Primary Phone: 319/331.3570 Alternate Phone:

Primary Insurance Co Wellmark Blue Cross/Blue Shield Primary Group/Policy # 003326401 / UQKAN8823538

Family Physician Name Dr. Jill Flory Physician Phone 319/364.8704

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

None

Please list any medications currently being taken:

None

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:

None

If None, please write None.

Participant Signature (regardless of age): Date: 11/13/2020

Participant, Peyton Anderson, 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: 11/13/2020

Relationship to Participant: Mother

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: 11/13/2020

Parent/Guardian

or

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

Signature: Date: 11/13/2020

Parent/Guardian