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 Team Name: Fire Dragons

Brenna (First Name) Williams (Last Name) 12/9/07 (Birth Date) 12 (Age) ☐ Male ☒ Female

Primary Contact: Parent or Guardian

Name: Corie Williams Address: 4088 Kansas Ave SW

City, State & Zip IC IA 52246

Primary Phone: 319-541-4520 Alternate Phone: —

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

Name: Tony Williams

Primary Phone: 319-541-2028 Alternate Phone: —

Primary Insurance Co BC/BS Primary Group/Policy # 53596 / XQHW004343 36

Family Physician Name Dr. Miller Physician Phone 319-339-1231

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): X Brenna Williams Date: 11/22/2020

Participant, Brenna Williams, 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: [signature] Date: 11/22/2020

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: [signature] Date: 11/22/2020

Parent/Guardian

or

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

Signature: _____ Date: _____

Parent/Guardian

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YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

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By signing this form the participant affirms having read and agreed to the terms and conditions listed below.

Club: Hot Feet Five Dragons Team Name: 17u

Caitlyn	Williams	4-25-04	16	☐ Male ☒ Female
First Name	Last Name	Birth Date	Age	

Primary Contact: Parent or Guardian

Name: Corie Williams Address: 4088 Kansas Ave SW

City, State & Zip IC IA 52246

Primary Phone: 319-541-4520 Alternate Phone: —

Secondary Contact: ☒ **Parent/Guardian** ☐ **Other** _____

Name: Tony Williams

Primary Phone: 319-541-2028 Alternate Phone: —

Primary Insurance Co BC/BS Primary Group/Policy # 53596 / XQH W00434336

Family Physician Name Dr. Miller Physician Phone 319-339-1231

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): X Caitlyn Williams Date: 11/22/2020

Participant, Caitlyn Williams, 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: 11/22/2020

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: 11/22/2020

Parent/Guardian

or

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

Signature: _____ Date: _____

Parent/Guardian

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By signing this form the participant affirms having read and agreed to the terms and conditions listed below.

Club: Hot Feet Team Name: Fire Dragons

Brenna (First Name) Williams (Last Name) 12/9/07 (Birth Date) 12 (Age) ☐ Male ☒ Female

Primary Contact: Parent or Guardian

Name: Corie Williams Address: 4088 Kansas Ave SW

City, State & Zip IC IA 52246

Primary Phone: 319-541-4520 Alternate Phone: —

Secondary Contact: ☒ **Parent/Guardian** ☐ **Other** _____

Name: Tony Williams

Primary Phone: 319-541-2028 Alternate Phone: —

Primary Insurance Co BC/BS Primary Group/Policy # 53596 / XQHW004343336

Family Physician Name Dr. Miller Physician Phone 319-339-1231

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): X Brenna Williams Date: 11/22/2020

Participant, Brenna Williams, 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: 11/22/2020

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: 11/22/2020
Parent/Guardian

or

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

Signature: _____ Date: _____
Parent/Guardian

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By signing this form the participant affirms having read and agreed to the terms and conditions listed below.

Club: Hot Feet Fire Dragons Team Name: 17u

First Name	Last Name	Birth Date	Age	☐ Male	☒ Female
Caitlyn	Williams	4-25-04	16		

Primary Contact: Parent or Guardian

Name: Corie Williams Address: 4088 Kansas Ave SW

City, State & Zip IC IA 52246

Primary Phone: 319-541-4520 Alternate Phone: —

Secondary Contact: ☒ **Parent/Guardian** ☐ **Other** _____

Name: Tony Williams

Primary Phone: 319-541-2028 Alternate Phone: —

Primary Insurance Co BC/BS Primary Group/Policy # 53596 / XQH W00434336

Family Physician Name Dr. Miller Physician Phone 319-339-1231

Please elaborate on <u>any medical conditions</u> of which we should be aware:

none

Please list any <u>medications</u> 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 <u>allergies</u>:

none

If None, please write None.

Participant Signature (regardless of age): X Caitlyn Williams Date: 11/22/2020

Participant, Caitlyn Williams, 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: 11/22/2020

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: 11/22/2020
Parent/Guardian

or

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

Signature: _____ Date: _____
Parent/Guardian