# YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

be kept in the possession of authorized adult team	personnel and that reason	nable care will be used	d to keep thi	s information co	gree that this infidential.	document will
By signing this form the participant affirms having Club:	read and agreed to the to		The same of the sa	1/1	<b>~</b> (	
Brenna	Williams	_ Team Name	1 1	e Diagon		₩ <sub>5</sub> ,
	Last Name		2 9 07 Birth Dat	e Age	☐ Male	Female
Primary Contact: Parent or Guardian	6					
Name: Corie Will	liams	Address:	4088	s Kanso	is Ave	SW
Primary Phana 210 GILL 615	20	City, State & Zip	ic	A 522	246	
Primary Phone: 3 19-541-45	20	Alternate Phone:				
Secondary Contact: A Parent/Guardia						
Name: Tony Wil	liams -					
Primary Phone: 319-541-	2028	Alternate Phone:	1,000	>		
Primary Insurance Co BCBS		Primary Group/Po	olicv# =	53596 1	XOHINIO	0434336
Family Physician Name	er	Physician Phone	-	319-334	_	715755
Please elaborate on any medical conditions of which we should be aware:						
No	ne					
Please list any medications currently being						
non						
In the past 24 months, have you been tested If yes, provide the date (months and year),	d, diagnosed and/or to who performed the te	reated for a concus sting/diagnosing/t	ssion: 🔲 v	Yes 🗖 No and what was	the outcom	ne:
Please list any <u>allergies</u> : When the second						
If None, please write None.						
Participant Signature (regardless of age):	Williams	Date:	11 22 :	2020		
Participant, BYCMNA In	Silliams	,	has my per	mission to part	icipate in trai	ning.
competition, events, activities and travel sponso	red by USA Volleyball or	any of its Regional V	olleyball A	ssociations (RVA	As). Lapprove	e of the
leaders who will be in charge of this program. I	recognize that the leader	rs are serving to the	best of the	ir ability. I certi	fy that the pa	irticipant has
full medical insurance with the company listed a adult team personnel and that reasonable care with the company listed and the company li	will be used to keep this?	agree that this docui	ment Will b ntial Lagre	e kept in the po	ssession of a	uthorized
personnel to release this information in the ever	nt of a medical emergenc	cy to a third party me	edical provi	der. I also certif	y to the best	of my
knowledge that the participant named hereon is	physically fit to engage	in the activities descr	ribed above	e.		,
Parent/Guardian Signature:			Date	: 11/22/2	<u> 2020</u>	
Relationship to Participant:	ther			, ,		
If, during the course of my daughter's/son's activemergency medical/dental care   will assume fi Signature:	rities in volleyball, she/ho nancial responsibility for	e should become ill c the bills incurred th	rough myli	n injury, I herek nsurance compa 22   2020	oy authorize y any.	ou to obtain
or						
I do not authorize emergency medical/dental care for my daughter/son.  Signature:  Date:						
Signature: Date: Date:						
			***************************************			

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: eet five Dragons Team Name: ☐ Male **Ž** Female First Name Last Name Birth Date Age **Primary Contact: Parent or Guardian** Williams Name: Address: City, State & Zip Primary Phone: 319-541.4520 Alternate Phone: A Parent/Guardian **Secondary Contact: □**Other Tony Williams Name: Primary Phone: Alternate Phone: Primary Insurance Co Primary Group/Policy # 53596 1X0H W00434336 or miller Family Physician Name 319 - 339 - 1231 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: Types Types 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 OMA Date: Participant Signature (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 hamed hereon is physically fit to engage in the activities described above. Parent/Guardian Signature: Relationship to Participant: If, during the course of mydaughter's/son's activities in volley all, 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

Signature:
Parent/Guardian

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

Date:

2020-2021 Season

## 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: ☐ Male 🕅 Female First Name Last Name Birth Date Primary Contact: Parent or Guardian Name: Address: City, State & Zip Primary Phone: Alternate Phone: **Secondary Contact:** Parent/Guardian **□**Other Name: Williams Primary Phone: Alternate Phone: Primary Insurance Co Primary Group/Policy # XQHW00434336 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:  $\square$  Yes 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: Relationship to Participant: If, during the course of my daughter's/son's activities in voleyball, 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 mylinsurance company. Signature: Parent/Guardian or I do not authorize emergency medical/dental care for my daughter/son. Signature: Date: Parent/Guardian

# 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 gareed to the terms and conditions listed below.

club: Hot Feet Five Dyagons	Team Name: \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \				
Caitlyn William					
First Name Last Name	Birth Date Age				
Primary Contact: Parent or Guardian  Name: Corie Williams  Primary Phone: 319-541-4520	Address: 4088 Kansas Ave Sw City, State & Zip Alternate Phone:				
Secondary Contact: A Parent/Guardian Other Name: Tony Williams Primary Phone: 319-541-2028	Alternate Phone:				
ON 5 1 2003	- Attendate Friends				
Primary Insurance Co  Family Physician Name  BC/BS  Dr. Miller	Primary Group/Policy # <u>53594</u> / <u>XQH W004343</u> Physician Phone <u>319 - 339 - 1231</u>				
Please elaborate on <u>any medical conditions</u> of which we should be aware:					
Please list any <u>medications</u> currently being taken:					
In the past 24 months, have you been tested, diagnosed and/or treated for a concussion:  Yes You 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> :					
If None, please write None./					
Participant Signature (regardless of age):  Participant, Competition, events, activities and travel sponsored by USA Volle leaders who will be in charge of this program. I recognize that the full medical insurance with the company listed above. I understate adult team personnel and that reasonable care will be used to ke	Date:				
If, during the course of my daughter's/son's activities in volleybal emergency medical/dental care. I will assume financial responsibility Signature:  Parent/Guardian  or	I, she/he should become ill or sustain an injury, I hereby <b>authorize</b> you to obtain oility for the bills incurred through my insurance company.  Date: 1 22 2020				
	d-11-11-11-11-11-11-11-11-11-11-11-11-11				
I <b>do not authorize</b> emergency medical/dental care for my of Signature:  Parent/Guardian	daughter/sonDate:				