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

Sadie Hebl 2-4-08 12 ☐ Male ☒ Female
First Name Last Name Birth Date Age

Primary Contact: Parent or Guardian
Name: Carole Ann Hebl Address: 1583 Upper Oldtown Rd NW
City, State & Zip Oxford MA 5[illegible]
Primary Phone: (319) 330-9187 Alternate Phone: (319) 430-1016

Secondary Contact: ☐ Parent/Guardian ☐ Other Kenneth Hebl
Name: Kenneth Hebl
Primary Phone: (319) 430-1016 Alternate Phone: (319) 828-4993

Primary Insurance Co _____ Primary Group/Policy # _____ / _____
Family Physician Name _____ Physician Phone _____

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: _____

Participant, Sadie Hebl, 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: Carole Ann Hebl Date: 11-15-2020

Relationship to Participant: Mother

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.

nature: Carole Ann Hebl Date: 11-15-2020
Parent/Guardian

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

ature: _____ Date: _____
Parent/Guardian