



USA Volleyball

2004 USA YOUTH & JUNIOR OLYMPIC VOLLEYBALL PLAYER MEDICAL HISTORY AND RELEASE FORM

This **must be** completed - legibly - and signed in all areas by both the player and his or her parent or guardian.
By signing this form the participant affirms having read it. **A copy of this form must be carried with the coach for all training and competitions.**

Name _____
Last First

Birth Date _____ Age _____ Gender _____ Social Security Number _____

Parent or Guardian:

Name _____

Address _____

_____ Zip _____

Home Phone _____

Work Phone _____

Team Name _____ Division _____

Family Physician Name _____

In Emergency, Contact:

Name _____

Home Phone _____

Work Phone _____

Primary Insurance Co. _____

Primary Group/Policy # _____

Does policy cover sport related accidents? _____ Yes _____ No

Physician Phone _____

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 also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Signed _____ Date: _____

Relationship: _____

To the Club Leaders:

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.

Signed: _____ Date: _____

Parent or Guardian

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

Signed: _____ Date: _____

STATE OF _____) COUNTY OF _____)
SWORN TO BEFORE ME, a Notary Public, by said _____ personally known
to me this _____ day of _____, 20_____.

Notary Public
My Commission Expires _____

Immunizations (please state month and year)

Tetanus _____ Polio _____ Measles(Rubella) _____

Health History

	Yes	No	Date	Please elaborate (especially on those conditions that might be aggravated)
Allergies	_____	_____	_____	_____
Asthma	_____	_____	_____	_____
Congenital problem	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____
Heart	_____	_____	_____	_____
Ankle Injuries	_____	_____	_____	_____
Knee Injuries	_____	_____	_____	_____
Back Injuries	_____	_____	_____	_____
Head/Neck Injuries	_____	_____	_____	_____
Shoulder Injuries	_____	_____	_____	_____
Elbow Injuries	_____	_____	_____	_____
Wrist Injuries	_____	_____	_____	_____
Hand Injuries	_____	_____	_____	_____
Finger Injuries	_____	_____	_____	_____
Other Injuries	_____	_____	_____	_____

1) Height _____ Weight _____

2) Is there any psycho-social or physical condition for which the participant is currently under professional care?
NO _____ YES _____

3) Is the participant currently taking any medications? NO _____ YES _____
If so, please name the drug(s), dosage and frequency needed:

4) List any known allergies:

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

6) Comments:

7) Please list any injuries the participant has suffered in the last two months:

8) State special instructions to follow in case of emergency _____
