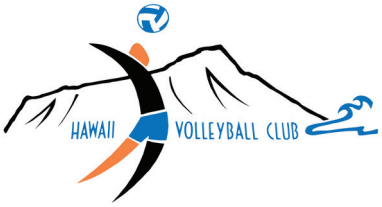

USA YOUTH & JUNIOR OLYMPIC VOLLEYBALL
PLAYER MEDICAL HISTORY AND RELEASE FORM

PRINT PARTICIPANT'S NAME: _____
Last First

BIRTH DATE _____ AGE:_____ M/F: _____ EMAIL _____

PARENT OR GUARDIAN:

NAME: _____

ADDRESS: _____

_____ ZIP _____

HOME PHONE: _____

CELL _____

WORK PHONE: _____

PHYSICIAN NAME _____

PHYSICIAN PHONE _____

IN EMERGENCY, CONTACT:

NAME: _____

HOME PHONE: _____

CELL: _____ WORK PHONE _____

PRIMARY INSURANCE CO: _____

GROUP/POLICY#: _____

DOES POLICY COVER SPORTS-RELATED ACCIDENTS? _____
Y OR N

PARTICIPANT, _____, HAS MY PERMISSION TO PARTICIPATE IN TRAINING, COMPETITION, EVENTS, ACTIVITIES AND TRAVEL SPONSORED BY USA VOLLEYBALL OR ANY OF ITS REGIONAL VOLLEYBALL ASSOCIATIONS. I APPROVE 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.

SIGNATURE: _____ DATE: _____ RELATIONSHIP _____

To the Club Leaders:

If during the course of my daughter's/son's activities in volleyball, she/he should be 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.

PARENT/GUARDIAN SIGNATURE _____ DATE: _____

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

PARENT/GUARDIAN SIGNATURE _____ DATE: _____

PARTICIPANT NAME: _____

Immunizations (please state month and year)

Tetanus _____ Polio _____ Measles (Rubella) _____

Health History

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

Height _____ **Weight** _____

Is there any psycho-social or physical condition for which the participant is currently under professional care?

No _____ Yes _____

Is the participant currently taking medications? No _____ Yes _____
If so, please name the drug(s), dosage and frequency needed:

_____

List any known allergies:

_____

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

_____

Comments: _____

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

_____

State special instructions to follow in case of emergency:

_____