

WSY – Junior Volleyball Medical Release Form

This must be completed – legibly – and signed in all areas by both the player and their parent/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 agree to the terms and conditions listed below.***

Club: West Shore YMCA

Club Team Age Group (Ex. U15): _____

First Name: _____ Last Name: _____ DOB: _____ Age: _____

Primary Contact: Parent or Guardian

Name: _____

Address: _____

Primary Phone: _____

City, State & Zip: _____

Secondary Contact: Parent or Guardian

Name: _____

Primary Phone: _____

Primary Insurance Co: _____

Primary Group/Policy # _____ / _____

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: Yes or No

Please list any allergies (If none, please write none):

Participant, _____ has my permission to participate in training, competition, events, activities, and travel sponsored by AAU Volleyball. 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: _____

Relationship to Participant: _____

If, during the course of my daughter's activities in volleyball, she 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.

Parent/Guardian Signature: _____ Date: _____