



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

WEST SHORE YMCA GIRLS JUNIOR VOLLEYBALL CLUB MEDICAL RELEASE FORM

This form 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 (e.g. U15): _____

First Name: _____ **Last Name:** _____

Primary Contact: Parent or Guardian

Name: _____	Address: _____
Primary Phone: _____	City, State, Zip: _____

Secondary Contact: Parent or Guardian

Name: _____	Primary Phone: _____
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Primary Insurance: _____	Group / Policy #: _____ / _____
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 No

Please list any allergies (if none, 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 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: _____