THIS FORM IS TO BE CARRIED BY THE COACH TO ALL SANCTIONED COMPETITIONS AND PRACTICES.

NORTHWEST JUNIORS VOLLEYBALL PLAYER MEDICAL RELEASE FORM

This must be completed – legibly – and signed in all areas by <u>both</u> the player and his/her parent or guardian.

By signing this form the participant affirms having read it.

Club Program: ____________________

Player Name:____ ____

Last First Birth Date Age Gender

Primary Contact: Parent or Guardian

Name:____

Address:____Zip:________________________

Phone:________________________ Alternate Phone: __________________ E-mail: _____________________________

Secondary Contact: ____Parent or Guardian ____ Other

Name:____

Address:____Zip:________________________

Phone:________________________ Alternate Phone: __________________ E-mail: _____________________________

Primary Insurance Co.______________________________________ Primary Group/Policy #________________________

Family Physician Name:____ Physician Phone:_________________________

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

____

Any Medications Currently being taken:____

Any allergies:____

If none please write NONE:______________________

Signed____ Date:____________________________

Participant, ____ has my permission to participate in training, competition, events, activities and travel sponsored by Northwest Volleyball, Inc. 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:____ Relationship:__________________ Date:__________

If, during the course of my daughter's activities in volleyball, she should become ill or sustain an injury, I hereby ***<u>authorize</u>*** you to obtain emergency medical/dental care. I will assume financial responsibility for the bills incurred through my insurance company.

Signed:____ Relationship:__________________ Date:__________

<u>OR:</u>

I ***<u>do not authorize</u>*** emergency medical/dental care for my daughter.

Signed:____ Relationship:__________________ Date:__________