2025-2026 REGIONAL GIRLS MEDICAL RELEASE FORM

This **must be** completed - legibly - and signed in all areas by both the player and his/her parent or 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 agreed to the terms and conditions listed below.

Club: _____

Player Name: _____

Team Name: _____

Birth Date: _____ Age: ____

Gender: _____

Primary Contact:

Relationship: _____

Email Address: _____

Phone: _____

Secondary Contact:

Relationship: _____

Email Address: _____

Phone: _____

Insurance Information and Medical Contact:

Primary Insurance Company: _____.

Primary Group #: _____.

Primary Policy #: _____

Physician Name: _____

Physician Phone: _____

Emergency Contact #: _____

Please elaborate on <u>any medical conditions</u> of which we should be aware:

Please list any <u>medications</u> currently being taken:

In the past 24 months, have you been tested, diagnosed, or treated for a concussion:

If yes, provide the date (months and year), who performed the testing/diagnosing/treatment and what was the outcome:

Allergies:

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 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 Signature: _____ Date: _____

Relationship to Participant: _____

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

Parent Signature: _____ Date: _____

Relationship to Participant: _____