



## 2005 USA YOUTH & JUNIOR OLYMPIC VOLLEYBALL PLAYER MEDICAL HISTORY AND RELEASE FORM

This **must be** completed - legibly - and signed in all areas by both the player and his or her parent or guardian.  
*By signing this form the participant affirms having read it. A copy of this form must be carried with the coach for all training and competitions.*

Name \_\_\_\_\_  
Last First

Birth Date Age Gender Social Security Number

**Parent or Guardian:**

Name \_\_\_\_\_

Address \_\_\_\_\_

Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Team Name \_\_\_\_\_ Division \_\_\_\_\_

Family Physician Name \_\_\_\_\_

**In Emergency, Contact:**

Name \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Primary Insurance Co. \_\_\_\_\_

Primary Group/Policy # \_\_\_\_\_

Does policy cover sport related accidents? \_\_\_\_\_ Yes \_\_\_\_\_ No

Physician Phone \_\_\_\_\_

Signed \_\_\_\_\_ Date: \_\_\_\_\_  
Participant

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 also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Signed \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_

**To the Club Leaders:**

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

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Guardian

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

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Immunizations** (please state month and year)

Tetanus \_\_\_\_\_ Polio \_\_\_\_\_ Measles(Rubella) \_\_\_\_\_

**Health History**

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

1) Height \_\_\_\_\_ Weight \_\_\_\_\_

2) Is there any psycho-social or physical condition for which the participant is currently under professional care?  
NO \_\_\_\_\_ YES \_\_\_\_\_

3) Is the participant currently taking any medications? NO \_\_\_\_\_ YES \_\_\_\_\_  
If so, please name the drug(s), dosage and frequency needed:

\_\_\_\_\_

4) List any known allergies:

\_\_\_\_\_

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

\_\_\_\_\_

6) Comments:

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

\_\_\_\_\_

8) State special instructions to follow in case of emergency \_\_\_\_\_

\_\_\_\_\_