



USA Volleyball
Bayou Regional Volleyball Association
 Player Medical History and Release Form



PLEASE PRINT CLEARLY

Participant Name: _____ Male
 _____ Female
 Last Name, First Name, M.I.

Date of Birth: / / Current Age: Social Security #
mm dd yy

Parent / Guardian:

Name: _____
Last Name First Name

Street Address: _____

City, ST, Zip _____

Phone H: _____
 Contacts: W: _____
 C: _____

In Emergency, contact:

Name: _____
Last Name First Name

Phone H: _____
 Contacts: W: _____
 C: _____

Insurance Company _____
 Group/Policy # _____

To whom it may concern:

Participant, _____, has my permission to participate in training, competition, events, activities and travel sponsored by a USA Volleyball national and regional Junior Olympic Volleyball program. I approve of the leaders who will be in charge of the club. I recognize that the leaders are serving to the best of their ability and in consideration of the benefits to be derived by the participant concerned, 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.

Signature: _____ Date: _____

Relationship to participant: _____

To the Club Leaders:

If during the course of my son's/daughter's activities in volleyball, should he/she become ill or sustain an injury, **I hereby authorize** you to obtain emergency medical / dental care.

Signature: _____ Date: _____
Parent / Guardian

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

Signature: _____ Date: _____
Parent / Guardian

Notary Signature: _____ Date: _____

Where applicable by state (Not required in Louisiana.)

This form must be available at all times during organized activities involving this participant.



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Male
 Female

Date of Birth: / / Current Age: Social Security #
mm dd yy

Immunizations

(please state month and year)

Tetanus / /
mm yy

Polio / /
mm yy

Measles (Rubella) / /
mm yy

Health History

	Yes (y)	No (n)	Date (mm / yy)	Please elaborate, especially to those conditions 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	_____	_____	_____	_____

- Height: _____ Weight: _____
- Is there any psychosocial or physical condition for which the participant is currently under professional care?
 Yes No
- Is the participant currently taking any medication? Yes No
 If yes, please name the drug(s) and dosage prescribed.
 Drug _____ Drug _____ Drug _____
 Dosage _____ Dosage _____ Dosage _____
- List any known drug allergies: _____

- Please elaborate on any medical conditions we should be aware of: _____

- Please list any injuries the participant has received in the last two months: _____
 Explain: _____

- Comment on any special condition already listed or not. _____

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