

AAU VOLLEYBALL & Sierra Volleyball Club Inc.
THIS FORM IS TO BE CARRIED TO ALL SANCTIONED COMPETITIONS & PRACTICES.

PLAYER MEDICAL RELEASE FORM

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

_____ Last First Birth Date Age Gender Primary Contact: _____ Parent / Guardian ___ Other

Name: _____

Email: _____

Cell Phone: _____ Alternate Phone: _____

Primary Insurance Company: _____ Primary Group/Policy

_____ Family Physician Name: _____ Physician Phone

#: _____

Signed: _____ Date: _____ Participant

Participant, _____, has my permission to participate in training, competition, events, activities and travel sponsored by AAU or any of its AAU Associations. 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: _____

Please elaborate on any medical conditions of which we should be aware of: Any Medications currently taken:
Any Allergies:
If none, Please write None

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

Or

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

Signed: _____ Date: _____ Parent or Guardian

STATE OF _____) COUNTY OF _____

SWORN TO BEFORE ME, a Notary Public, by said _____ personally known to me this _____ day of _____, 20_____.

_____ My Commission Expires

_____ Notary Public

Revised 06/30/15