

SAMPLE FORM ONLY! This is a REQUIRED form and it must be completed online, printed, and sent to the NCVA Office in order to complete your registration.

CLUB NAME: _____

USA YJOV Player Medical History and Release Form

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

Last Name: _____ First Name: _____

Birth Date: _____ Age: _____ Gender: Male Female

Parent or Guardian:

In Emergency, Contact:

Name: _____

Name: _____

Address: _____

Home Phone: _____

City, State: _____ Zip: _____

Work Phone: _____

Home Phone: _____

Primary Insurance Co.: _____

Work Phone: _____

Primary Group/Policy #: _____

Family Physician: _____

Does policy cover sports-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: _____

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Last Name: _____ First Name: _____

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Immunizations (please state month and year)

Tetanus: _____ Polio: _____ Measles(Rubella): _____

Health History	Yes	No	Date	Please elaborate (especially on 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	_____	_____	_____	_____

1. Height: _____ Weight: _____

2. Is the participant currently under professional care for any psycho-social or physical condition?

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: _____