



SCVA/USA VOLLEYBALL MEDICAL HISTORY & RELEASE FORM

<i>Check one!</i> <input type="checkbox"/> Male <input type="checkbox"/> Female

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

PARTICIPANT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ Gender: _____ Social Sec. #: _____

PARENT/GUARDIAN INFORMATION

Full Name: _____

Complete Address: _____

Home Phone: _____

Work Phone: _____

Club Name: _____

PHYSICIAN/INSURANCE INFORMATION

Physician Name: _____

Physician Phone: _____

Primary Insurance Co.: _____

Primary Group/Policy #: _____

Does policy cover sport-related accidents? **Y** **N**

EMERGENCY CONTACT INFORMATION

Full Name: _____

Home Phone: _____ Work Phone: _____

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: _____ *Relationship:* _____ *Date:* _____

TO THE CLUB LEADERS:

If, during the course of my son/daughter's activities in volleyball, he/she should become ill or sustain an injury:

_____ I DO authorize the Club Leader to obtain emergency medical or dental care.

_____ I DO NOT authorize the Club Leader to obtain emergency medical or dental care.

Signed: _____ *Relationship:* _____ *Date:* _____

BOTH SIDES OF THIS FORM MUST BE COMPLETED AND SIGNED

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 condition	_____	_____	_____	_____
Ankle injury	_____	_____	_____	_____
Knee injury	_____	_____	_____	_____
Head/Neck injury	_____	_____	_____	_____
Shoulder injury	_____	_____	_____	_____
Elbow injury	_____	_____	_____	_____
Wrist injury	_____	_____	_____	_____
Hand injury	_____	_____	_____	_____
Finger injury	_____	_____	_____	_____
Other injuries	_____	_____	_____	_____

- 1) Height _____ Weight _____
- 2) Is there any psychosocial or physical condition for which the participant is currently under professional care? Y N
- 3) Is the participant currently taking any medication? Y N
If so, please name the drug(s), dosage and frequency needed: _____

- 4) List any known allergies: _____
- 5) Please elaborate on any medical condition that we should be aware of: _____

- 6) Please list any injuries the participant has suffered in the last two months: _____
- 7) Please state any special instructions to follow in case of emergency: _____

- 8) Comments: _____

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