



PLAYER MEDICAL RELEASE FORM

This **must be** completed - legibly - and signed in all areas by both the player and his/her parent or guardian. I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. **By signing this form the participant affirms having read and agreed to the terms and conditions listed below.**

Team Name: _____

First Name _____ Last Name _____ Birth Date _____ Age _____

Primary Contact: Parent or Guardian

Name: _____ Address: _____
 City, State & Zip _____
 Primary Phone: _____ Alternate Phone: _____

Secondary Contact: Parent/Guardian Other _____

Name: _____
 Primary Phone: _____ Alternate Phone: _____

Primary Insurance Co _____ Primary Group/Policy # _____ / _____
 Family Physician Name _____ Physician Phone _____

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

 Please list any medications currently being taken:

 In the past 24 months, have you been tested, diagnosed and/or treated for a concussion: Yes No
 If yes, provide the date (months and year), who performed the testing/diagnosing/treatment and what was the outcome:

 Please list any allergies:

 If None, please write None.

Participant Signature _____ Date: _____
(regardless of age):

Participant, _____, has my permission to participate in training, competition, events, activities and travel sponsored by FCA Maryland Volleyball (FCAMDVVB). 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 (if no insurance, "N/A"). I understand and agree that this document will be kept in the possession of authorized adult team personnel and that reasonable care will be used to keep this information confidential. I agree to allow the authorized adult team personnel to release this information in the event of a medical emergency to a third party medical provider. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

Parent/Guardian Signature: _____ Date: _____

Relationship to Participant: _____

If, during the course of my player's activities in volleyball, she 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.
 Signature: _____ Date: _____
 Parent/Guardian

or

I do not authorize emergency medical/dental care for my daughter/son.
 Signature: _____ Date: _____
 Parent/Guardian