



## Medical Information and Release

EFFECTIVE FROM SEPTEMBER 2016 – AUGUST 2017

### Player Information:

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

### Parent or Guardian:

### In Emergency Contact:

NAME: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

\_\_\_\_\_ ZIP \_\_\_\_\_

CELL/WORK PHONE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

CELL/WORK PHONE: \_\_\_\_\_

PRIMARY INS. CO.: \_\_\_\_\_ PRIMARY GROUP/POLICY ID: \_\_\_\_\_

RELATIONSHIP TO PLAYER: \_\_\_\_\_

### MEDICAL RELEASE

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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date