



Medical Information and Release

Player Information:

NAME: _____ DOB: _____

ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP CODE: _____

Parent or Guardian:

NAME: _____

ADDRESS: _____

_____ ZIP _____

HOME PHONE: _____

CELL/WORK PHONE: _____

RELATIONSHIP TO PLAYER: _____

In Emergency Contact:

NAME: _____

HOME PHONE: _____

CELL/WORK PHONE: _____

PRIMARY INS. CO.: _____

PRIMARY GROUP/POLICY ID: _____

To the Tournament Directors:

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



ON-SITE ADULT CONFIRMATION

I, _____, hereby confirm that I am the on-site contact for the following juniors:

1. _____

2. _____

3. _____

4. _____

As the on-site contact for the aforementioned juniors, I agree to adhere to the FVC tournament policy which states "An adult MUST be on-site at ALL times for any junior under the age of 16."

Signature

Date

Printed Name

On-Site Phone # (Cell)