

**Wisconsin Ice Volleyball Club**

**2501 Springville Dr**

**Plover, WI 54467**

**JUNIOR VOLLEYBALL COACH MEDICAL RELEASE FORM**

This **must be** completed - legibly - and signed in all areas by the coach. 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.***

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| Club: |  | | | | | | | | | | | | | | | Team Name: | | | | |  | | | | | | | | | | | | |
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| First Name | | | | | | | | | | | Last Name | | | | | | | | Birth Date | | | | | | | Age | | | |  | | | |
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| **Primary Contact in the event of an emergency:**   |  |  |  | | --- | --- | --- | | **□ Family Member** | **□Other** |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | |  | | | | | | | | | | | Address: | | | | | |  | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | City, State & Zip | | | | | |  | | | | | | | | | | | | |
| Primary Phone: | | | |  | | | | | | | | | | | Alternate Phone: | | | | | |  | | | | | | | | | | | | |
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| **Secondary Contact:** | | | | | **□ Family Member** | | | | | | | **□Other** | |  | | | | | | | | | | |  | | | | | | | | |
| Name: | | | |  | | | | | | | | | | |  | | | | | |  | | | | | | | | | | | | |
| Primary Phone: | | | |  | | | | | | | | | | | Alternate Phone: | | | | | |  | | | | | | | | | | | | |
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| Primary Insurance Co | | | | | | |  | | | | | | | | | Primary Group/Policy # | | | | | | | |  | | | | | | | | / |  |
| Family Physician Name | | | | | | |  | | | | | | | | | Physician Phone | | | | | | | |  | | | | | | | | | |
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| Please elaborate on any medical conditions of which we should be aware: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Please list any medications currently being taken: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| If None, please write None. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Coach Signature | | | | | |  | | | | | | | | | | | Date: | |  | | | | | | | | |  | | | | | |
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| I am participating as a coach 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 I have full medical insurance with the company listed above. 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 I am physically fit to engage in the activities described above. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| If, during the course of my activities in volleyball, I 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: | | | |  | | | | | | | | |  | | |
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| I **do not authorize** emergency medical/dental care for me. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature: | |  | | | | | | | | | | | | | | | | Date: | | | |  | | | | | | | | |  | | |
|  | | Parent/Guardian | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | |