

**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.***

|  |  |  |  |
| --- | --- | --- | --- |
| Club: |  | Team Name: |  |
|  |  |  |  |  |  |  |  | □ Male □ Female |
| First Name | Last Name | Birth Date | Age |  |
|  |  |  |  |  |
| **Primary Contact in the event of an emergency:**

|  |  |  |
| --- | --- | --- |
| **□ Family Member** | **□Other** |  |

 |
| Name: |  | Address: |  |
|  |  | City, State & Zip |  |
| Primary Phone: |  | Alternate Phone: |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Secondary Contact:** | **□ Family Member** | **□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. |
|  |  |  |  |  |
| Coach Signature  |  | Date: |  |  |
|  |  |  |  |  |
|   |  |  |  |  |
|  |  |  |
| 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: |  |  |
|  |  |  |  |
| or |  |  |  |  |
|  |  |  |  |  |
| I **do not authorize** emergency medical/dental care for me. |
| Signature: |  | Date: |  |  |
|  | Parent/Guardian |  |  |