SKILLZ FINEST VOLLEYBALL PLAYER
MEDICAL RELEASE FORM (20__ - 20__ Season)

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.***

First Name ______ Last Name ______ Birth Date ______ Age ______ **SKILLZ Team** ______

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 **SKILLZ FINEST** 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 the participant has 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 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 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: ______
Parent/Guardian

or

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