



# SCVA/USA VOLLEYBALL MEDICAL HISTORY & RELEASE FORM

<i>Check one!</i> <input type="checkbox"/> Male <input type="checkbox"/> Female
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*This form **must be completed** – legibly – and signed in all areas by both the player and his/her parent or guardian. By signing this form the participant affirms having read it. A copy of this form must be carried with the coach for all training and competitions.*

## PARTICIPANT INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Social Sec. #: \_\_\_\_\_

## PARENT/GUARDIAN INFORMATION

Full Name: \_\_\_\_\_

Complete Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Club Name: \_\_\_\_\_

## PHYSICIAN/INSURANCE INFORMATION

Physician Name: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Primary Insurance Co.: \_\_\_\_\_

Primary Group/Policy #: \_\_\_\_\_

Does policy cover sport-related accidents? **Y** **N**

## EMERGENCY CONTACT INFORMATION

Full Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Participant, \_\_\_\_\_, has my permission to participate 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 the participant has full medical insurance with the company listed above. I also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.

*Signed:* \_\_\_\_\_ *Relationship:* \_\_\_\_\_ *Date:* \_\_\_\_\_

## TO THE CLUB LEADERS:

If, during the course of my son/daughter's activities in volleyball, he/she should become ill or sustain an injury:

\_\_\_\_\_ I DO authorize the Club Leader to obtain emergency medical or dental care.

\_\_\_\_\_ I DO NOT authorize the Club Leader to obtain emergency medical or dental care.

*Signed:* \_\_\_\_\_ *Relationship:* \_\_\_\_\_ *Date:* \_\_\_\_\_



**IMMUNIZATIONS** (please state month and year)

Tetanus \_\_\_\_\_ Polio \_\_\_\_\_ Measles(Rubella) \_\_\_\_\_

**HEALTH HISTORY**

	Yes	No	Date	Please elaborate (especially on those conditions that might be aggravated)
Allergies	_____	_____	_____	_____
Asthma	_____	_____	_____	_____
Congenital problem	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____
Heart condition	_____	_____	_____	_____
Ankle injury	_____	_____	_____	_____
Knee injury	_____	_____	_____	_____
Head/Neck injury	_____	_____	_____	_____
Shoulder injury	_____	_____	_____	_____
Elbow injury	_____	_____	_____	_____
Wrist injury	_____	_____	_____	_____
Hand injury	_____	_____	_____	_____
Finger injury	_____	_____	_____	_____
Other injuries	_____	_____	_____	_____

- 1) Height \_\_\_\_\_ Weight \_\_\_\_\_
- 2) Is there any psychosocial or physical condition for which the participant is currently under professional care?    Y    N
- 3) Is the participant currently taking any medication?    Y    N  
If so, please name the drug(s), dosage and frequency needed: \_\_\_\_\_  
\_\_\_\_\_
- 4) List any known allergies: \_\_\_\_\_
- 5) Please elaborate on any medical condition that we should be aware of: \_\_\_\_\_  
\_\_\_\_\_
- 6) Please list any injuries the participant has suffered in the last two months: \_\_\_\_\_
- 7) Please state any special instructions to follow in case of emergency: \_\_\_\_\_  
\_\_\_\_\_
- 8) Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BOTH SIDES OF THIS FORM MUST BE COMPLETED AND SIGNED**