Petite Elite

YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

This must be completed – legibly – and signed in all areas by both the player and her parent or guardian. I understand and agree that this document will be kept in the possession 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: Texas Elite Volleyball Association (TEVA) Team Name: Petite Elite

______________________	______________________	____/____/______	_____	Female
Participant First Name	Participant Last Name	Birth Date	Age	Gender

Primary Contact: Parent or Guardian

Name: ______________________ Primary Phone: ______________________

Address: ______________________ City: ______________________ Zip: _______

Secondary Contact: ☐ Parent or Guardian ☐ Other ______________________

Name: ______________________ Primary Phone: ______________________

Address: ______________________ City: ______________________ Zip: _______

Primary Insurance

Company: ______________________ Group / Policy #: ____________ / ________________

Physician: ______________________ Primary Phone: ______________________

Please elaborate on any medical conditions of which we should be aware:	Please list any medications currently being taken:	Please list any allergies: If none, please write NONE

In the past 24 months, has the participant been tested, diagnosed and/or treated for a concussion: ☐ Yes ☐ No

Participant Signature: ______________________ Date: ______________________

Participant, ______________________, has my permission to participate in training, competition, events, activities and travel associated with Texas Elite Volleyball Association (TEVA). 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 activities in volleyball, she should be 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.

Parent / Guardian Signature: ______________________ Date: ______________________

I **do not authorize** emergency medical / dental care for my daughter.

Parent / Guardian Signature: ______________________ Date: ______________________