# Texas Petite Elite Volleyball
# Youth & Junior Medical Release

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 Grade Level: _____

| _____ Participant First Name | _____ Participant Last Name | ____/____/_____ Birth Date | _____ Age | Female 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: _____