

417 NET RESULTS VOLLEYBALL CLUB

PARTICIPANT INFORMATION

NAME _____
FIRST MIDDLE LAST

FIRST NAME USED/PREFERRED: _____

PERMANENT HOME ADDRESS _____
STREET CITY ST ZIP

HOME TELEPHONE _____ SOCIAL SECURITY NUMBER _____

DATE OF BIRTH _____ PLACE OF BIRTH (City/State/Country) _____

NAME OF PARENT/ GUARDIAN _____ WORK TELEPHONE _____

NAME OF PARENT/ GUARDIAN _____ WORK TELEPHONE _____

PERSON TO NOTIFY IN CASE OF EMERGENCY _____ RELATIONSHIP _____

EMERGENCY TELEPHONE (H) _____ EMERGENCY TELEPHONE (W) _____

INSURANCE COMPANY _____ GROUP/POLICY # _____

MEDICAL RELEASE

I realize that sports involve a potential for injury. I understand that even with the best supervision and protective equipment and medical care, serious injuries are still a possibility.

I hereby grant permission for athletic screening, a physical exam and, in case of injury, to have an athletic trainer and/or medical doctor provide me with medical assistance and/or treatment. I indemnify and hold harmless 417 NET RESULTS VOLLEYBALL CLUB, its agents, including the team trainer from any injury, condition, disability or expense resulting directly or indirectly from the performance or failure to perform proper first aid and/or medical care. If I am under 16 years of age, a parent/guardian must provide consent for me to be given medical assistance and/or treatment by signing below. **Primary insurance coverage of said athlete must be complete below.**

NAME OF CARRIER _____

ADDRESS OF CARRIER _____

POLICY NUMBER _____

PARTICIPANT'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

MEDICAL HISTORY

Have you ever had, or been treated for any of the following conditions? If the answer to any of the conditions is "YES", please state if the condition is *active* = still under care, or *inactive* = condition resolved. Please use additional page for explanations if any answer is active.

	YES	NO		YES	NO
Epilepsy	_____	_____	Seizure	_____	_____
Hepatitis	_____	_____	Mononucleosis	_____	_____
Rheumatic fever	_____	_____	Heart murmur	_____	_____
Scarlet fever	_____	_____	Loss consciousness	_____	_____
Nerve injury	_____	_____	Eye injury	_____	_____
Fracture	_____	_____	Dislocation	_____	_____
Severe sprain	_____	_____	Back pain	_____	_____
Curved spine	_____	_____	Hernia	_____	_____
Nervous disorder	_____	_____	Kidney disease	_____	_____
High blood pressure	_____	_____	Tuberculosis	_____	_____
Ulcers	_____	_____	Blood in urine	_____	_____
Diabetes	_____	_____	Sugar in urine	_____	_____
Blood in the stool	_____	_____	Tendonitis	_____	_____

Have you ever had to stay in the hospital over night?	_____	_____
Have you ever had surgery?	_____	_____
Are you now under the regular care of a physician?	_____	_____
Are you now under the regular care of an Osteopath?	_____	_____
Are you now under the care of a health professional?	_____	_____
Have you ever been told in the past that physical activities should be limited?	_____	_____
Do you have any worries about your health? or think there may be any reason why you may not be able to participate in this sport?	_____	_____
Are there any questions, which you would like to discuss with your doctor that you have not?	_____	_____
Is there anything else of any nature of which 417 NET RESULTS VB should be aware?	_____	_____
Date of your last tetanus shot: _____		

I certify the above statements are true.

PARTICIPANT'S SIGNATURE _____ DATE _____