

FLORIDA AAU VOLLEYBALL PROGRAM

MEDICAL HISTORY AND RELEASE FORM

This form must be carried with the coach during all training and competitions. Please complete all sections of this form. Both the player and his or her parent/guardian must sign in all appropriate areas. By signing this form, the participant and parent/guardian affirms they have read and understand it.

LAST NAME _____ FIRST NAME _____ MI _____ (CIRCLE ONE) M F

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

BIRTH DATE _____ / _____ / _____ AGE _____ SOCIAL SECURITY No. _____ AAU MEMBERSHIPS No. _____

TEAM NAME _____ DIVISION _____ HEIGHT _____ WEIGHT _____

The Participant, _____, has permission to participate in the AAU Junior National Volleyball Program. I certify that the participant has full medical insurance with the company listed below and is physically fit to engage in the activities of the program. I approve the leaders and coaches of this program and recognize that they will serve to the best of their ability.

MUST SIGN: _____ Date: _____
PARTICIPANT SIGNATURE

MUST SIGN: _____ Relationship: _____
PARENT/GUARDIAN SIGNATURE

Print Name: _____ HOME PHONE _____ WORK PHONE _____
PARENT/GUARDIAN

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP POLICY # _____ DOES THIS POLICY COVER SPORTS RELATED ACCIDENTS?
(CIRCLE ONE) YES NO

MEDICAL RELEASE:

If my son or daughter should become ill or sustain an injury during his or her activities of the volleyball program, I hereby authorize you to obtain emergency medical/dental care.

SIGN: _____ Date: _____
PARENT/GUARDIAN SIGNATURE

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

SIGN: _____ Date: _____
PARENT/GUARDIAN SIGNATURE