Tryout Number _____ Age Division _____ Volleyball Position(s)_____

Player Full Name_____

Please attach a headshot/picture to this form along with a copy of the USAV Medical Waiver

Birthday _____ Grade and school _____

Player Cell _____ Player Email_____

Address & City _____

Parent(s) Name(s) _____

Parent(s) Cell(s) _____

Parent email for club communication _____

Former experience/Teams _____

I give permission for my daughter, _____ to participate in the Surfside Volleyball tryouts. As with any physical activity, I understand that there is a possibility of injury to my daughter. We have our own medical insurance to cover my daughter should she become injured during the tryout. I understand that Hayley Blanchard, Jessica Kalama, Julianna Hicks, Loriann Perkins and all Surfside Volleyball Club "Staff", do not have insurance for any injuries which may occur and will not hold them responsible. I hereby indemnify, defend and hold harmless Surfside Volleyball Club, Inc. and its owners, officers, agents, volunteers and employees ("Club") from any and all claims arising out of injury, accidents, or illness to my child (named above) while participating in any Club clinics, tryouts, training, practices, tournaments, Club events and activities ("Club Activities"), as well as travel associated with Club Activities.

Any medical conditions we should be aware of _____

Parent Signature _____ Date _____

THIS FORM IS TO BE CARRIED TO ALL SANCTIONED COMPETITIONS & PRACTICES.

USAV YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

This **must be** completed - legibly - and signed in all areas by both the player and his/her parent or guardian. 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. ***By signing this form the participant affirms having read and agreed to the terms and conditions listed below.***

Club: _____ Team Name: _____

☐ Male ☐ Female

First Name _____ Last Name _____ Birth Date _____ Age _____

Primary Contact: Parent or Guardian

Name: _____ Address: _____

City, State & Zip _____

Primary Phone: _____ Alternate Phone: _____

Secondary Contact: ☐ **Parent/Guardian** ☐ **Other** _____

Name: _____

Primary Phone: _____ Alternate Phone: _____

Primary Insurance Co _____ Primary Group/Policy # _____ / _____

Family Physician Name _____ Physician Phone _____

Please elaborate on any medical conditions of which we should be aware:

Please list any medications currently being taken:

In the past 24 months, have you been tested, diagnosed and/or treated for a concussion: ☐ Yes ☐ No
If yes, provide the date (months and year), who performed the testing/diagnosing/treatment and what was the outcome:

Please list any allergies:

If None, please write None.

Participant Signature (regardless of age): _____ Date: _____

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 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/son's activities in volleyball, she/he should 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.

Signature: _____ Date: _____
Parent/Guardian

or

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

Signature: _____ Date: _____
Parent/Guardian