

2011 TEAM INDIANA MEDICAL RELEASE FORM

***This must be completed and signed in all areas by both the player and a parent or guardian.
By signing this form, the participant and parent affirms having read it.***

Club

Team Name

Name: Last, First, Middle Initial

Age Date of Birth

Primary Contact | Parent/Guardian

Name

Relationship

Phone

Alternative Phone

Address

City, State, Zip

Secondary Contact | Parent/Guardian or Other

Name

Relationship

Phone

Alternative Phone

Insurance and Physician Information

Primary Insurance Company

Primary Group/Policy #

Primary Insurance Company

Primary Group/Policy #

Medical Conditions *Use back side if needed.*

Please elaborate on any medical conditions of which we should be aware (if none, please write none.):

Any medications currently taking:

Any allergies:

Athlete's Signature

Date

Athlete, _____, has my permission to participate in training, competition, events, activities and travel associated with Team Indiana Volleyball or any of its associations. 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 also certify to the best of my knowledge that the athlete named hereon is physically fit to engage in activities associated with Team Indiana Volleyball Club.

Parent/Guardian Signature

Date

If during the course of the athlete's activities in volleyball, she 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.

Parent/Guardian Signature

Date

or

I do **NOT AUTHORIZE** emergency medical/dental care for my daughter.

Parent/Guardian Signature

Date

