JUNIOR VOLLEYBALL PLAYER PARTICIPATION & MEDICAL AUTHORIZATION FORM

This **must be** completed - legibly - and signed in all areas by the player's 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 <u>any medical conditions</u> of which we should be aware:

Please list any <u>medications</u> 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 <u>allergies</u>:

If None, please write None.

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: _____

CHOOSE ONLY ONE OPTION BELOW:

OPTION 1: 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

OPTION 2: I **do not authorize** emergency medical/dental care for my daughter/son.

Signature: _____ Date: _____
Parent/Guardian

Concussion Management and Sudden Cardiac Arrest Acknowledgement

The Puget Sound Region of USA Volleyball believes participation in athletics improves physical fitness, coordination, self-discipline, and gives students valuable opportunities to learn important social and life skills.

With this in mind it is important we do as much as possible to create and maintain an enjoyable and safe environment. As a parent/guardian or student athlete you play a vital role in protecting participants and helping them get the best from sport.

Player and family education in this area is crucial which is the reason for the Concussion Management and Sudden Cardiac Arrest Awareness pamphlet you received. Refer to it regularly.

This acknowledgement must be signed annually by the parent/guardian and student athlete prior to participation in Puget Sound Region Volleyball events. If you have questions regarding any of the information provided in the pamphlet, please contact the athletic director at your school.

ZACHERY LYSEDT LAW COMPLIANCE STATEMENT
I certify:

1) I have been provided with information on concussions in youth sports in compliance with HB 1824.

2) I understand that on a yearly basis, the concussions in youth sports information sheet shall be signed and returned to the Puget Sound Region, USAV by myself (or my parent or legal guardian if I am under the age of eighteen (18) years old) prior to my initiating practice or competition.

3) If any player/participant is suspected of suffering a concussion or brain injury, the player will be removed from practice or competition and not returned to practice or competition until cleared in writing by a licensed health care provider trained in the evaluation and management of concussions (Medical Doctors, Doctors of Osteopathy, Advanced Registered Nurse Practitioner, Physicians Assistants, and Certified Athletic Trainers).

I have received, read, and understand the information presented within the Sudden Cardiac Arrest Pamphlet.

_____	_____	_____
Student Athlete (Printed)	*Student Athlete (Signed)*	*Date*
_____	_____	_____
Parent/Guardian Name (Printed)	*Parent/Guardian (Signed)*	*Date*