

# RIVER FALLS VOLLEYBALL CLUB PLAYER MEDICAL HISTORY AND RELEASE FORM

This must be completed legibly, and signed in all areas by both the player and his or her parent or guardian. By signing this form the participant affirms having read it. A copy of this form will be carried with the coach for all training and competitions.

Name \_\_\_\_\_  
Last Middle First

Birthdate Age Gender M/F Social Security Number

**Parent or Guardian:**

**In Emergency, Contact:**

Name \_\_\_\_\_ Name \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
\_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_  
Home Phone \_\_\_\_\_ Primary Insurance Co. \_\_\_\_\_  
Work Phone \_\_\_\_\_ Primary Group/Policy # \_\_\_\_\_  
Physician Name \_\_\_\_\_ Physician Phone \_\_\_\_\_

Participant, \_\_\_\_\_, has my permission to participate in training, competition, events, activities and travel sponsored by the River Falls Volleyball Club or any of its directors, board members, volunteers, employees and other associated personnel. 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 participant named hereon is physically fit to engage in the activities described above.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Relationship: \_\_\_\_\_

**TO THE CLUB LEADERS:**

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

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Guardian

**I do not** authorize emergency medical/dental care for my daughter/son. ***I further acknowledge that by signing this, I agree to attend all training (practices) and competitions (games), and assume full responsibility for care in the event of a medical emergency.***

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Guardian

Name : \_\_\_\_\_

**Immunizations (please state month and year)**

Tetanus \_\_\_\_\_ Polio \_\_\_\_\_ Measles (Rubella) \_\_\_\_\_

**Health History**

	Yes	No	Date	Please elaborate (especially on those that might be aggravated)
Allergies	_____	_____	_____	_____
Asthma	_____	_____	_____	_____
Congenital Problem	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____
Heart	_____	_____	_____	_____
Ankle Injuries	_____	_____	_____	_____
Knee Injuries	_____	_____	_____	_____
Back Injuries	_____	_____	_____	_____
Head/Neck Injuries	_____	_____	_____	_____
Shoulder Injuries	_____	_____	_____	_____
Elbow Injuries	_____	_____	_____	_____
Wrist Injuries	_____	_____	_____	_____
Hand Injuries	_____	_____	_____	_____
Finger Injuries	_____	_____	_____	_____
Other Injuries	_____	_____	_____	_____

1) Height \_\_\_\_\_ Weight \_\_\_\_\_

2) Is there any psycho-social or physical condition for which the participant is currently under professional care?  
 No \_\_\_\_\_ Yes \_\_\_\_\_

3) Is the participant currently taking medications? No \_\_\_\_\_ Yes \_\_\_\_\_  
 If so, please name the drug(s), dosage and frequency needed:

\_\_\_\_\_

4) List any known allergies:

\_\_\_\_\_

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

\_\_\_\_\_

6) Comments: \_\_\_\_\_

\_\_\_\_\_

7) Please list any injuries the participant has suffered in the last two months: \_\_\_\_\_

\_\_\_\_\_

8) State special instructions to follow in case of emergency: \_\_\_\_\_

\_\_\_\_\_