

FLORIDA AAU VOLLEYBALL PROGRAM

MEDICAL HISTORY AND RELEASE FORM

It is recommended that this form 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

MEDICAL HISTORY

	<u>YES OR NO</u>		<u>DATE</u>	<u>PLEASE SPECIFY</u>
ALLERGIES	Y	N	_____	_____
ASTHMA	Y	N	_____	_____
DIABETES	Y	N	_____	_____
EPILEPSY	Y	N	_____	_____
HEADACHES	Y	N	_____	_____
HEART	Y	N	_____	_____
KIDNEY DISEASE	Y	N	_____	_____
MOTION SICKNESS	Y	N	_____	_____
INJURIES:				
ANKLE	Y	N	_____	_____
KNEE	Y	N	_____	_____
BACK	Y	N	_____	_____
HEAD/NECK	Y	N	_____	_____
SHOULDER	Y	N	_____	_____
ELBOW	Y	N	_____	_____
WRIST	Y	N	_____	_____
HAND	Y	N	_____	_____
FINGER	Y	N	_____	_____
OTHER	Y	N	_____	_____

IMMUNIZATIONS (please state month and year):

Tetanus _____ Polio _____ Measles (Rubella) _____

Is the participant taking any medications? NO YES

If yes, please name the drug(s), dosage and frequency needed:

Is there any psycho-social or physical condition for which the participant is currently under professional care?
 NO YES

Please list any injuries the participant has suffered in the last two months: _____

Elaborate on any other medical conditions: _____

STATE OF _____

COUNTY OF _____

SWORN TO BEFORE ME, A NOTARY PUBLIC, BY SAID _____ PERSONALLY

KNOW TO ME THIS _____ DAY OF _____, 20____.

 NOTARY PUBLIC

MY COMMISSION EXPIRES _____