

# FLORIDA AAU VOLLEYBALL PROGRAM

## MEDICAL HISTORY AND RELEASE FORM

**This form must 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 \_\_\_\_\_, 19 \_\_\_\_.

\_\_\_\_\_ NOTARY PUBLIC

MY COMMISSION EXPIRES \_\_\_\_\_