GEORGETOWN VOLLEYBALL
PLAYER MEDICAL RELEASE FORM

This **must be** completed - legibly - and signed in all areas by both the player and his/her parent or guardian. ***By signing this form the participant affirms having read it.***

Name _____
Last First Birth Date Age

Primary Contact: Parent or Guardian

Name_____ Address_____ Zip_____

Phone_____ Alternate Phone_____

Secondary Contact: ___ Parent/Guardian ___ Other

Name_____

Phone_____ Alternate Phone_____

Primary Insurance Co. _____ Primary Group/Policy #_____

Family Physician Name_____ Physician Phone_____

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

Any medications currently being taken:

Any allergies:

If None, please write None.

Signed _____ Date:_____
Participant

Participant, _____, has my permission to participate in training, events and activities sponsored by Georgetown College. 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_____ Relationship:_____ Date:_____

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

or

I **do not authorize** emergency medical/dental care for my daughter.

Signed:_____ Date:_____
Parent or Guardian