



# Western Empire Volleyball Association High Performance Program

## Tryouts, Camps and Teams

### Player Medical History and Release Form

58 Meadowlark Drive  
Penfield, NY 14526  
585-259-6557

[www.wevavolleyball.org](http://www.wevavolleyball.org)



USA Volleyball.

This form **must** be completed – legibly – and signed in all indicated areas by the participant and parent or guardian of the participant.

*By signing this form the participant's parents or guardians affirm having read it.*

**Athlete:**

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

Birth date \_\_\_\_\_ Current age \_\_\_\_\_ Gender \_\_\_\_\_

**Parent or Guardian:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

**Medical Information:**

Family Physician: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Primary Insurance Co: \_\_\_\_\_

Primary Group Policy #: \_\_\_\_\_

**Emergency Contact:**

Name \_\_\_\_\_

Relationship to athlete \_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

*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 also certify to the best of my knowledge that the participant named hereon is physically fit to engage in the activities described above.*

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to athlete \_\_\_\_\_

**To the staff:**

*If, during the course of my son / daughter's activities related to WEVA High Performance volleyball, he/she should become ill or sustain an injury, I hereby authorize you to obtain emergency medical / dental care.*

*I will assume financial responsibility for bills and costs incurred through my insurance company.*

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_