PLAYER MEDICAL HISTORY AND RELEASE FORM

Tel: (310) 913-0108
Email: volleyoki@gmail.com

This form must be completed legibly and signed in all areas by the participant and his or her parent or guardian if participant is under the age of 18 years. By signing this form the participant affirms having read it. A copy of this form must be carried with the participant for all training and competiions.

____
Last Name First Name

____
Birth Date Age Gender

Parent or Guardian :

Name____________________________________

Address__________________________________

____________________Zip_______________

Home Phone______________________________

Work Phone______________________________

Family Physician Name______________________

Physician Phone___________________________

In Emergency, Contact :

Name____________________________________

Home Phone______________________________

Work Phone______________________________

Primary Insurance Co. ________________________

Primary Group/Policy #_______________________

Does policy cover sport related accidents? ___Yes___No

Is the participant currently taking any medications? ___Yes___No

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

____

List any known allergies:

____

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

____

State special instructions to follow in case of emergency

____

I authorize that I am over the age of 18 years and can physically and mentally participate in training, competition, events, activities and instruction provided by Dennis Marlow and OKI Volleyball or any of its personnel. I approve of the clinicians who will be in charge of this program. I recognize that the clinicians are serving to the best of their ability. I certify that I, as the participant, have full medical insurance with the company listed above. I also certify to the best of my knowledge that I am physically fit to engage in the activities described above.

Signed: ____ Date: ____

(If under age 18)

Participant, __________________________ has my permission to participate in training, competition, events, activities and instruction provided by Dennis Marlow and OKI Volleyball or any of its 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:________________________________

Print Name______________________________________ Relationship:___________________________

To the Parents: 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.

Signed:________________________________ Date:________________________________