

## CT Juniors Medical Form (Sep 2017-Aug 2018)

This **must be** completed - legibly - and signed in all areas by both the player and his or her parent or guardian. *By signing this form the participant affirms having read it.* A copy of this form must be carried with the coach for all training and competitions.

Name \_\_\_\_\_  
Last First Birthdate Age Gender

**Primary Contact: Parent or Guardian:**

Name \_\_\_\_\_ Address \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

**Emergency Contact: Parent, Guardian or Other**

Name \_\_\_\_\_ Address \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Primary Insurance Co. \_\_\_\_\_ Primary Group/Policy # \_\_\_\_\_

Family Physician Name \_\_\_\_\_ Physician Phone \_\_\_\_\_  
Does policy cover sport related accidents? Yes No

Please elaborate on **ANY MEDICAL CONDITIONS** of which we should be aware:

**DATE OF LAST PHYSICAL:**

Any **MEDICATIONS** currently being taken:

Any **ALLERGIES**:

If **NONE**, please write **NONE**:

Participant, \_\_\_\_\_, has my permission to participate in training, competition, events, and activities sponsored by the Connecticut Junior Volleyball Association. 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: \_\_\_\_\_

Relationship: \_\_\_\_\_

**To the Club Leaders:**

If, during the course of my son/daughter's activities in 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 the bills incurred through my insurance company.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Guardian

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

Signed: \_\_\_\_\_ Date: \_\_\_\_\_