Iowa Volleyball Region

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Adult Medical Release & Contact Form

Updated September 2014

THIS FORM IS TO BE CARRIED TO ALL EVENTS & PRACTICES

First Name, MI, Last Name _____

Address _____ Age _____ Gender _____

City _____ Date of Birth _____

State Zip _____

IN CASE OF EMERGENCY CALL

PRIMARY CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

Cell Phone (_____) _____

SECONDARY CONTACT

Name _____

Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

Cell Phone (_____) _____

INSURANCE INFORMATION

Insurance Co _____ Primary Group/Policy# _____

Name of Policy Holder _____

Physician Name _____ Physician Phone _____

LIST MEDICAL CONDITIONS

_____

_____

_____

_____

ALLERGIES

_____

_____

_____

_____

MEDICATIONS BEING TAKEN-dosage if known

_____ _____

_____ _____

_____ _____

⇨ **I, _____, (**print name**) attest that this information is complete** and current as of this following date: _____ Signature _____

YOU MUST SIGN ONE OF THE OPTIONS BELOW

⇨ **I Authorize Treatment:** If, during the course of my volleyball activities, I 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**.**

Signature _____ **Date** _____

⇨ **I Do Not Authorize** Emergency medical /dental care.

Signature _____ **Date** _____