



## Player Medical History and Release Form

Tel: (310) 940-7166

Email: info@beachvolleyballcamps.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 arms having read it. A copy of this form must be carried with the participant for all training and competitions.

Last Name	First Name
Birth Date Age	Gender
Parent or Guardian : Name	In Emergency, Contact : Name
Address	Home Phone
Zip	Work Phone
Home Phone	Primary Insurance Co.
Work Phone	
Family Physician Name	
Physician Phone	Is the participant currently taking any medications?YesNo
If so, please name the drug(s), dosage and frequency n	
List any known allergies:	
Please elaborate on any medical conditions we should	be aware of:
State special instructions to follow in case of emergency	
who will be in charge of this program. I recognize that the	and & Sea Beach Camps or any of its personnel. I approve of the clinicians ne clinicians are serving to the best of their ability. I certify that I, as the ny listed above. I also certify to the best of my knowledge that I am physically
Signed:	Date:
(If under age 18) Participant, , h	as my permission to participate in training, competition, events, activities and
instruction provided by Beach Volleyball Camps, Sand will be in charge of this program. I recognize that the lea	& Sea Beach Camps or any of its personnel. I approve of the leaders who aders are serving to the best of their ability. I certify that the participant has also certify to the best of my knowledge that the participant named hereon is
Signed	Date:
Print Name	Relationship:
	on's activities in volleyball, she/he should become ill or sustain an injury, I tal care. I will assume financial responsibility for the bills incurred through my
Signed:	Date:
Parent or Guardian	Date
	v daughtar/can
I do not authorize emergency medical/dental care for m Signed:	
Jigiieu	_ Date: