2019-2020 Spark Volleyball Club Medical Waiver Form

Please print clearly

Player's Name: _____ Date of Birth: _____

Parent/Guardian Name:_____ Relationship:_____
Address: _____ City:_____
State: _____ Zip:_____ Home phone: _____
Work phone: _____ Cell phone: _____
Email: _____

Please indicate another person to call if an accident occurs and we are unable to reach you:
Name: _____ Phone No.: _____
Primary Care Giver's Insurance Information Company: _____
Policy No: _____ Insurance Company Contact #: _____
Secondary Insurance plan (if applicable) _____
Is your player presently on medication? _____
If yes, please list medication(s):

_____

Drug Sensitivities:

_____

Other Allergies:

_____

I, (the undersigned parent or guardian), do hereby authorize the athletic trainer or coaching staff of the Spark Volleyball Camps/Clinics to secure any and all medical treatment in the event that I cannot be contacted. I further authorize any attending physician to render any and all medical care which he/she may deem necessary. I release the Spark Volleyball Camps/Clinics, and all their affiliated entities from any and all liability, claims, demands, and causes of action for personal injury or loss suffered by my child in connection with participation in this Camp. I, (the undersigned parent of guardian), also certify that my child is physically fit to attend and participate in the Spark Volleyball Camps/Clinics.

_____ _____

Signature (Parent or Guardian) Date