

2019 Top Gun Volleyball Club

Player Information and Medical History Form – 12U

Athlete's Information:

Name _____ Date of Birth ____/____/____ Age _____

Address _____ City _____ Zip _____

School _____ Grade _____ T-shirt: Specify Adult or Youth and Size: _____

Home Phone Number (____) _____ Top Three Uniform Number Choices _____

Please send email communication to: _____

Father's Information:

Mother's Information:

Name _____ Name _____

Work/Cell Phone (____) _____ Work/Cell Phone (____) _____

Insurance Information:

Primary Insurance Co. _____ Insurance Co. Phone (____) _____

Primary Group/Policy # _____ Policy Holder's Name _____

Family Physician's Name _____ Physician's Phone (____) _____

In Case of Emergency, Contact: (after parents)

Name Relationship Phone

Medical Information:

All known allergies: _____

Any medical conditions that we should be aware of: _____

Medications my daughter is currently on: _____

Name of drug(s), dosage and frequency: _____

My daughter wears contact lenses: (circle one) Yes No

My daughter wears removable orthodontic devices: Yes No

My daughter carries and uses an inhaler to alleviate asthmatic symptoms: Yes No

I give permission to the Top Gun VBC coaching staff to give non-prescription medications to my daughter if needed. I will allow the circled medication below. **If none are circled, we will not administer any of the medications.**

Acetaminophen (Tylenol)

Ibuprofen – (Motrin, Advil)

In the event of an emergency, I authorize the Top Gun VBC staff and associates to act on my behalf to secure any and all medical/dental attention necessary for the health and safety of my daughter until such time that I may be contacted. I also assume responsibility for any and all payment of such treatment.

Parent Signature

Date Signed

Parent Signature

Date Signed