



Iowa Volleyball Region



4600 Park Ave, Ste 201
Des Moines, IA 50321-1237
P: 515-727-1860
F: 515-727-1861

HP Tryout Registration Form

Updated: March 7, 2012

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP _____

USAV DIVERSITY INFO

Needed for US Olympic Committee
(Voluntary)

- African American or Black
- Asian or Pacific Islander
- Caucasian (White, not Hispanic origin)
- Hispanic or Latino
- Multiracial or Mixed Race
- Native American or Alaskan Native
- Native Hawaiian or Other Pacific Islander

BIRTHDATE: ____/____/____ **GRAD YR** ____ **GRADE** ____

Age Groups

____ **GYNT - Born in 1996 & 1997**

____ **GSEL - Born in 1998, 1999, or after**

***E-MAIL:** _____

***Required for membership verification & tryout notification.**

Those selected will be posted on website approx. 2 weeks after the final tryout.

HOME PHONE: (____) _____ **CELL:** (____) _____

USAV Iowa Region Member #: _____

****All Participants must have a USAV Iowa Region membership.**

***Full membership: \$50**

***One day membership: \$15 (can later upgrade to full for \$35)**

***Event membership: \$5 (upgrade later is full \$50)**

TRYOUT FEE: \$35 for paper form or at the door

(GOOD FOR ALL DATES) Fee covers facility & staff costs.

(Online registration is \$25; see website for instructions—if you register and pay online, you do NOT need to turn in this form)

Mail forms to:

Iowa Volleyball Region
4600 Park Ave. Suite 201
Des Moines, IA 50321

Fax to: 515-727-1861

Questions, call 515-727-1860

Email to: colleen@iavbreg.org

Web Site: www.iavbreg.org

All forms of payment accepted in advance with paper form.

For credit card payment call 515-727-1860.

If paying at tryout, cash or check only.

CHECK any tryouts you will be attending (You may check more than one.)

____ **MAR 11**...Cornell College, Mt Vernon

____ **MAR 16**...Iowa Events Center, Des Moines

____ **MAR 23**...Iowa Events Center, Des Moines

____ **MAR 25** ...Marshalltown CC

____ **APR 1**Buena Vista Univ., Storm Lake

Position: Left side Right side Middle Setter Libero

You may mark more than one position

Dominant Hand: Right Left

-----Below: For Official Use Only-----Below: For Official Use Only-----

Paid: _____ Ck # _____ CCard _____ **Group:** _____

Shirt Number: _____

Date Received: _____ Medical Release Received: _____

THIS FORM IS TO BE CARRIED TO ALL SANCTIONED COMPETITIONS & PRACTICES.



2011-2012 USAV YOUTH & JUNIOR VOLLEYBALL PLAYER MEDICAL RELEASE FORM

This must be completed - legibly - and signed in all areas by both the player and his/her parent or guardian. By signing this form the participant affirms having read it.

Club: _____ Team Name: _____

Male Female

First Name _____ Last Name _____ Birth Date _____ Age _____

Primary Contact: Parent or Guardian

Name: _____ Address: _____
City, State & Zip _____
Primary Phone: _____ Alternate Phone: _____

Secondary Contact: Parent/Guardian Other _____

Name: _____
Primary Phone: _____ Alternate Phone: _____

Primary Insurance Co _____ Primary Group/Policy # _____ /
Family Physician Name _____ Physician Phone _____

Please elaborate on any medical conditions of which we should be aware:
Any medications currently being taken:
Any allergies:
If None, please write None.

Participant Signature _____ Date: _____
(regardless of age):

Participant, _____, has my permission to participate in training, competition, events, activities and travel sponsored by USA Volleyball or any of its Regional Volleyball Associations (RVAs). 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.

Parent/Guardian Signature: _____ Date: _____

Relationship to Participant: _____

If, during the course of my daughter's/son's activities in volleyball, she/he 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: _____
Parent/Guardian

or

I do not authorize emergency medical/dental care for my daughter/son.
Signature: _____ Date: _____
Parent/Guardian