# 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

NAME:_____

ADDRESS: _____

CITY, STATE, ZIP _____

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

**Age Groups**

**_____GYNT - Born in 1996 & 1997**

**_____GSEL - Born in 1998, 1999, or after**

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

***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: $5 (can be used multiple times, and can later be upgraded to full for $45)

**T-shirt Size** (adult sizes): _____

**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 22**…Marshalltown CC

____**APR 7** ...CR Kennedy HS

____**APR 12**....Des Moines--Drake

____**APR 19** ...Des Moines—Varied Industries

____**APR 26** …Des Moines—Varied Industires

____**MAY 5** …Western Iowa (location TBD)

**Position:** ☐ Left side ☐ Right side ☐ Middle ☐ Setter ☐ Libero
You may mark more than one position

**Dominant Hand:** ☐ Right ☐ Left

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

# 2012-2013 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 <u>any medical conditions</u> of which we should be aware:

Any <u>medications</u> currently being taken:

Any <u>allergies</u>:

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