



Iowa Volleyball Region



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Adult Participation Medical Release & Contact Form

Updated: January 21, 2010



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

This **must be** completed - legibly - and signed in all areas.

Last Name/, First Name _____

Address _____ Age _____ Gender _____

City _____ Date of Birth _____

State, Zip _____

IN CASE OF EMERGENCY CALL

Primary Contact Name: _____ **Secondary Contact Name:** _____

Relationship _____ Relationship _____

Home Phone _____ Home Phone _____

Cell Phone _____ Cell Phone _____

Work Phone _____ Work Phone _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Primary Group/Policy # _____

Family Physician Name _____ Physician Phone _____

Please elaborate on any medical conditions of which we should be aware:

If None, please write None. _____

Any medications currently being taken: _____ **Any Allergies** _____

By signing this form the participant affirms having read it.

Signed: _____ Date: _____

You must sign either the first or the second statement below.

If, during the course of my activities in volleyball, I 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.

Signed: _____ Date: _____

Or, I do not authorize emergency medical/dental care

Signed: _____ Date: _____