

THIS FORM REMAINS IN EFFECT FOR ALL PROGRAMS THAT THE PLAYER PARTICIPATES IN NOW AND IN THE FUTURE. IT IS THE SOLE RESPONSIBILITY OF THE FAMILY TO INFORM US OF ANY CHANGES TO THE INFORMATION BELOW. *Please initial...*

(/)
(player / parent)



CT Impact, LLC

MEDICAL HISTORY AND RELEASE FORM

CT Impact volleyball

WORK HARD, PLAY TOUGH, MAKE AN **IMPACT**
www.ctimpact.org • (203) 207-0050

This form **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.**

NAME _____
Last First Birth Date Age Gender

PRIMARY CONTACT

NAME _____
PHONE _____ ALTERNATE PHONE _____

SECONDARY CONTACT *Parent or Guardian* *Other*

NAME _____
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, ESPECIALLY IF THEY ARE AGGRAVATED BY PARTICIPATION IN SPORTS (I.E., ASTHMA). **IF NONE, PLEASE WRITE "NONE".**

ANY **MEDICATIONS** CURRENTLY BEING TAKEN:

ANY **ALLERGIES:**

SIGNED _____ DATE _____
Participant

If Participant Is OVER the Age of 18

I agree to participate in training, competition, events, and activities by CT Impact, LLC. 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.

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 _____

If Participant Is UNDER the Age of 18

I agree to allow my son/daughter to participate in training, competition, events, and activities by CT Impact, LLC. 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 my son/daughter named hereon is physically fit to engage in the activities described above.

SIGNED *parent or guardian* _____ DATE _____

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.

SIGNED *(parent or guardian)* _____ DATE _____

OR

I **do not authorize** emergency medical/dental care for my daughter/son.

SIGNED *(parent or guardian)* _____ DATE _____