

MEDICAL RELEASE 2011
Happy Volley Club Championships

Note: Each participant must have a medical release signed by her parent/legal guardian.

Falcon Volleyball Club	17	
Team Name/Club	Team Level	
_____	_____	
Last name	First name	Middle initial
_____	_____	_____
Date of Birth (mm/dd/yyyy)	Age	
_____	_____	
Home address (no. and street or box no.)	Home phone	
_____	_____	
City	State	ZIP code
_____	_____	_____
Parent's/Legal guardian's daytime phone	Home phone	
_____	_____	
Cell phone (if applicable)		

MEDICAL TREATMENT AUTHORIZATION

I hereby authorize the clinical staff of University Health Services, Penn State Hershey Orthopaedics-State College, and Mount Nittany Medical Center to provide emergency care that includes routine diagnostic procedures (i.e., x-rays, blood and urine tests) and medical treatment as necessary to my minor son/daughter,

I understand that the consent and authorization herein granted do not include major surgical procedures and are valid only during the camp. Physical conditions that the clinician should be aware of (allergies, _____, recurring illnesses, disabilities, chronic illnesses, etc.): _____

Date of most recent tetanus immunization: _____ (If more than ten years ago, a booster shot is recommended.)

In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact me. However, in the event of an emergency, and if I cannot be reached, I give my consent for physicians and staff at University Health Services, Penn State Hersey Orthopaedics-State College, and the Emergency/Outpatient Department of Mount Nittany Medical Center to perform any necessary emergency treatment. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider.

Name of emergency contact	Phone	
_____	_____	
Name of family physician	Phone	
_____	_____	
Parent's or legal guardian's name (please print)	Signature	
_____	_____	
	Date	
_____	_____	
Insurance company	Insurance company address (no. and street or box no.)	
_____	_____	
City	State	ZIP code
_____	_____	_____