



Vision Volleyball Club Player Information Form

Checklist for Player Information

The following are to be submitted to your team's parent rep:

- ☐ Player Information and Medical Form (This Form)
- ☐ Athlete Code of Conduct Signed by the Player
- ☐ Parent Code of Conduct Signed by the Each Parent/Guardian who will participate in any of the VVC activities
- ☐ Copy of Birth Certificate

Player's Name: _____

Home Phone: _____ Player Cell: _____

Address: _____

Player's Date of Birth: Day: _____ Month: _____ Year: _____

Parent/Guardian #1: _____ Relationship: _____

Daytime Phone: _____ Cell: _____

Email: _____

Parent/Guardian #2: _____ Relationship: _____

Daytime Phone: _____ Cell: _____

Email: _____

Player and Parent Commitment and Code of Conduct Agreement

As the parent/guardian of the above player, I give my consent for them to participate as a member of a team on the Vision Volleyball Club.

As a player of Vision Volleyball Club, I have read and understand the expectations of me as a member of Vision Volleyball Club as outlined in the "Club Handbook"

Media/Photo Release

Player and parent, hereby grant permission to the Vision Volleyball Club to use photographs and/or recorded images and/or voice on still or motion picture film and/or audio tape, and to use this material to promote the Vision Volleyball Club through the media of newsletters, websites, television, film, radio, print and/or display form. We understand that the audio/visual material and copyright will remain the sole property of the Vision Volleyball Club and waive any claim to remuneration for use of audio/visual materials used for these purposes. We understand that we may withdraw such consent at any time by contacting the Vision Volleyball Club.

Signature of Parent/Guardian: _____ Date: _____

Signature of Player _____ Date: _____



Vision Volleyball Club

Medical Profile Form

Player's Name: _____

Date of Birth: Day: _____ Month: _____ Year: _____ Height: _____ Weight: _____

Emergency Contact #1 Name: _____ Relationship: _____

Phone: _____ Cell: _____ Email: _____

Emergency Contact #2 Name: _____ Relationship: _____

Phone: _____ Cell: _____ Email: _____

Health Card #: _____ Name on Card: _____

Family Physician Name and Phone #: _____

List any Allergies to Drugs or Food: _____

List any Disabilities or Previous Medical Conditions: _____

Please Check Each Line Below:

Do you have any permanent disabilities? Yes___ No___

If yes, specify: _____

Do you wear glasses? Yes___ No___

Do you wear contact lenses? Yes___ No___

Do you wear braces, false teeth, bridges, etc.? Yes___ No___

Do you wear a hearing aid or hearing implant? Yes___ No___

Do you carry an EpiPen? Yes___ No___

Do you wear a medic alert bracelet? Yes___ No___

If yes, what is written on it? _____

Do you have or have had any of the following?

Arthritis or Rheumatism..... Yes___ No___

Headaches..... Yes___ No___

Asthma Yes___ No___

Hernia Yes___ No___

Chronic Nosebleeds..... Yes___ No___

Skin Condition..... Yes___ No___

Diphtheria Yes___ No___

Stomach Problems..... Yes___ No___

Dislocating Shoulder Yes___ No___

Swollen or Painful Joints..... Yes___ No___

Dizziness Yes___ No___

Trick or Lock Knee Yes___ No___

Epilepsy Yes___ No___

Fainting Yes___ No___

Diabetes Yes___ No___

Heart Trouble Yes___ No___

Previous Breaks or Sprains..... Yes___ No___

If yes to any above, please elaborate: _____

Date of last tetanus immunization: _____ Blood type: _____

List of medications: _____

Who administers medications at sports events? _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Player: _____ Signature of Witness: _____