

PLAYER INFORMATION SHEET

PARTICIPANT'S NAME: _____

GENDER: _____ AGE: _____ HEIGHT: _____ SCHOOL _____ GRADE _____

ADDRESS: _____ CITY: _____ STATE _____ ZIP _____

BIRTHDAY: _____ T-shirt Size: _____

MOTHER: _____ CELL: _____ EMAIL _____

FATHER: _____ CELL: _____ EMAIL _____

FINANCIAL AND OTHER CONSIDERATIONS

Hawaii Jr. Volleyball Club, Inc. is a 501(c)(3) non-profit corporation. All expenses, such as gym rental, equipment (balls, carts, accessories), and administration (office supplies, postage, taxes, etc.) are paid from donations by its members. Those joining should expect the following expenses. Payment may be made with cash or check. We do not accept credit/debit cards. Venmo accepted. Checks should be made payable to Hawaii Jr. Volleyball Club (or HJVB).

\$20 – A one-time tryout fee

\$70 – A one-time equipment fee, includes club dryfit shirt

\$25 – Annual insurance from the Youth National Sports Association (NAYS)

\$68 – Monthly donation (or \$20 per clinic) should be made the first week of each month or the first Sunday in attendance. Donations are mandatory for participants in attendance. (ie. You do not need to make a donation for months that are not attended).

The full amount of donations may be tax deductible since there is no basis to determine a dollar value for this clinic. Please consult with your tax preparer regarding the deduction. Our federal non-profit identification number is 99-0311093.

Please note that this is an instructional clinic and not a babysitting service.

Volunteers: Parents waiting for their children will be encouraged to participate in assisting the coaches by helping to shag balls and making sure their children are not disruptive to the clinic.

I have read the above information and accept the terms of participation as stated.

Signature

Date

Please Print Name

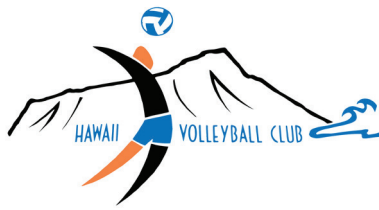
RELEASE OF LIABILITY/ACKNOWLEDGEMENT OF RISK SECTION

UPON ENTERING EVENTS SPONSORED BY HAWAII JR. VOLLEYBALL CLUB AND OR ITS MEMBER REGIONS/ ORGANIZATIONS, I/WE AGREE TO ABIDE BY THE RULES OF THE USAV AS CURRENTLY PUBLISHED. I/WE UNDERSTAND AND APPRECIATE THAT PARTICIPATION IN OR OBSERVATION OF THE SPORT CONSTITUTES A RISK TO ME/US OF SERIOUS INJURY, INCLUDING PERMANENT PARALYSIS OR DEATH. I/WE VOLUNTARILY AND KNOWINGLY RECOGNIZE, ACCEPT, AND ASSUME THIS RISK AND RELEASE OF THE HAWAII JR. VOLLEYBALL CLUB, ITS AFFILIATES, SPONSORS, EVENT ORGANIZERS, AND OFFICIALS FROM ANY LIABILITY THEREFORE.

Signature

Date

Please Print Name



PLAYER MEDICAL HISTORY AND RELEASE FORM

PRINT PARTICIPANT'S NAME: _____

Last

First

PHYSICIAN'S NAME: _____

PHYSICIAN PHONE _____

IN EMERGENCY, CONTACT:

NAME: _____

CELL: _____

PRIMARY INSURANCE CO: _____

GROUP/POLICY#: _____

DOES POLICY COVER SPORTS-RELATED
ACCIDENTS? _____ Y OR N

PARTICIPANT, _____,
HAS MY PERMISSION TO PARTICIPATE IN TRAINING,
COMPETITION, EVENTS, ACTIVITIES AND TRAVEL
SPONSORED BY USA VOLLEYBALL OR ANY OF ITS
REGIONAL VOLLEYBALL ASSOCIATIONS. I APPROVE 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.

SIGNATURE: _____

DATE: _____ RELATIONSHIP _____

Health History (Circle Any Conditions That May Apply to Participant)

Allergies Asthma Congenital Problem Diabetes Epilepsy Heart Ankle Injuries Knee Injuries Back Injuries Head/
Neck Injuries Shoulder Injuries Elbow Injuries Wrist Injuries Finger Injuries Other Injuries

Please elaborate on any injuries/conditions circled above. _____

List any known allergens _____ List of current medications _____

Has participant been Immunized for the following? (circle all that apply) Tetnus Polio Measles

Please state special instructions to follow in case of emergencies _____

To the Club Leaders:

If during the course of my daughter's/son's activities in volleyball, she/he should be become ill or sustain an injury, I hereby authorize you to obtain emergency medical/dental care if emergency contacts are unavailable.

I will assume financial responsibility for the bills incurred through my insurance company.

PARENT/GUARDIAN SIGNATURE _____ DATE: _____

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

PARENT/GUARDIAN SIGNATURE _____ DATE: _____