

## OKRVA JUNIOR TRYOUT APPLICATION 2008/09

This a Tryout Application and Medical Release form. This form is for the TRYOUT PROCESS ONLY – not as your permanent record for Registration for any team / club or USA Volleyball.

<b>PLAYER INFORMATION</b>	<b>Name</b>					
	<b>Address</b>					
	<b>Home Phone</b>					
	<b>Email Address</b>					
	<b>Year in School</b>			<b>Birthdate</b> MM DD YY		
	<b>Gender</b>	<input type="checkbox"/>	M	<input type="checkbox"/>	F	

<b>PARENT/GUARDIAN INFORMATION</b>	<b>Name</b>					
	<b>Relationship to Player</b>					
	<b>Address (if different)</b>					
	<b>Home Phone</b>					
	<b>Work Phone</b>					
	<b>Fax</b>					
	<b>Email Address</b>					

<b>EMERGENCY CONTACTS</b>	<b>Name</b>					
	<b>Phone</b>					
	<b>Name</b>					
	<b>Phone</b>					

<b>OTHER</b>	<b>Family Physician Name</b>					
	<b>Physician Phone</b>					
	<b>Name of Insurance</b>					
	<b>Ins Group # (if known)</b>					

<b>Club Name</b>		<b>Age Level</b>	
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Participant, (player's name) \_\_\_\_\_, has my permission to participate in training and tryout competition for this team / club, OkRVA and USA volleyball. 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 daughter / son activities in volleyball, 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 BY PARENT OR GUARDIAN DATE

**\*\*\*I do NOT authorize emergency medical / dental care for my daughter\*\*\***

\_\_\_\_\_  
SIGNED BY PARENT OR GUARDIAN DATE

**Please answer the following questions to the best of your ability**

Please list any injuries the participant has suffered in the last six months.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the participant currently taking any medications?  Yes  No

If so, please name the drug(s) dosage and frequency needed: \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Is there any psycho-social or physical condition for which the participant is currently under professional care? \_\_\_\_\_

Please use this section for your comments regarding your player's health.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**THIS TRYOUT FORM IS FOR INFORMATION PURPOSES ONLY!  
DO NOT ENTER THIS INFORMATION INTO THE ONLINE REGISTRATION SYSTEM.  
IF THE ABOVE LISTED PLAYER IS NOT JOINING THE SPECIFIC CLUB AS INDICATED  
ON THIS FORM, YOU MUST RETURN THIS FORM AND APPROPRIATE FEE TO THE  
REGION REGISTRATION OFFICE:**

**OKRVA  
1100 Melisa Dr  
Norman, OK 73071**

CLUB USE ONLY		
RECEIPT ISSUED AT	DATE ISSUED	AMOUNT PAID AT TRYOUT