



## Volleyball Clinic Medical Release Form

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
e-mail: \_\_\_\_\_  
Grade: \_\_\_\_\_  
School: \_\_\_\_\_

### Medical Release:

- I hereby authorize my child to participate in the weekly volleyball clinics to be conducted by the PDX)))VB Volley Ball Club at St Andrews.
- I know of no mental or physical problems which may affect my child's ability to safely participate in the clinic.
- I hereby authorize the coach and staff to act for me according to their best judgment in an emergency requiring medical attention.
- Neither I nor the above registered clinic participant will hold St Andrews, The Coach or Staff liable for any injuries, illness or expenses incurred while my son or daughter is involved in the PDX)))VB Volley Ball Club Clinic.

\_\_\_\_\_  
Signature (print name below)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Emergency Contact

\_\_\_\_\_  
Phone