INDIVIDUAL MEMBERSHIP FORM

First Name____________________MI_____Last Name_____________________

Address________________________________City________________________

State_________Zip_________Birthdate____________Phone_________________

Work Phone____________ Cell Phone ___________e-mail#_________________

Year last registered _______________ (State "new" if first year)

Current Team Name_____________________ Gender: ___F ___M

Shirt Size: S ____ M ____ L ____ XL ____

Jr. Level: ___U10 ___U12 ___U14 ___U16 ___U18

CLUB FEES: $ U10; U12 PAID________

$ U14; U16; U18 PAID________

I agree that I am affiliated with the above named team for the current season. Membership in EIVA and all the rights associated with this volleyball league.

Participant's Signature_____________________________Date_______________

Parent/Guardian's Signature_________________________Date_______________

Make Checks Payable To:

(Club Directors will issue one check to EIVA for all members from their club)

EIVA LEAGUE

Eastern Idaho Volleyball Assocation

Player Medical History and Release Form

This **must be** completed – legibly – and signed in all areas by both the player and his or her parent or guardian. By signing this form the participant affirms having read it. **A copy of this form must be carried with the coach for all training and competitions.**

Name ______________________________ ______________________________
Last First

____
Birth Date Age Gender Social Security Number

Parent or Guardian:

Name ______________________

Address ______________________

______________ Zip ________

Home Phone ______________________

Work Phone ______________________

Team Name __________ Division _____

Family Physician Name ______________

In Emergency, Contact:

Name ______________________

Home Phone ______________________

Work Phone ______________________

Primary Insurance Co. ______________________

Primary Group/Policy # ______________________

Does policy cover sport related accidents? ___Yes ___No

Physician Phone ______________________

Signed ______________________ Date ______________________
Participant

Participant, ______________________, has my permission to participate in training, competition, events, activities and travel sponsored by EIVA. 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.

Signed ______________________ Date ______________________

Relationship ______________________

To the Club Leaders:

If, during the course of my daughter's/son's activities in volleyball, she/he 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 ______________________ Date ______________________
Parent or Guardian

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

Signed ______________________ Date ______________________

Immunizations (please state month and year)

Tetanus ______________ Polio ______________ Measles (Rubella) ________________

Health History

Conditions	Yes	No	Date	Please elaborate (Especially on those that might be aggravated)
Allergies	____	____	______	____________________
Asthma	____	____	______	____________________
Congenital problem	____	____	______	____________________
Diabetes	____	____	______	____________________
Epilepsy	____	____	______	____________________
Heart	____	____	______	____________________
Ankle Injuries	____	____	______	____________________
Knee Injuries	____	____	______	____________________
Back Injuries	____	____	______	____________________
Head/Neck Injuries	____	____	______	____________________
Shoulder Injuries	____	____	______	____________________
Elbow Injuries	____	____	______	____________________
Wrist Injuries	____	____	______	____________________
Hand Injuries	____	____	______	____________________
Finger Injuries	____	____	______	____________________
Other Injuries	____	____	______	____________________

1) Height ______________ Weight ______________

2) Is there any psycho-social or physical condition for which the participant is currently under professional care?
NO ________ YES ________

3) Is the participant currently taking any medications? NO ________ YES ________
If so, please name the drug (s), dosage and frequency needed:

____

4) List any known allergies:

____

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

____

6) Comments:

7) Please list any injuries the participant has suffered in the last two months:

____

8) State special instructions to follow in case of emergency ____________________

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